PRINTED: 11/17/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFI AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY MPLETED
		445495	B, WING	_		10/	30/2014
NAME OF PROVIDE		COLLIERVILLE, LLC		49	TREET ADDRESS, CITY, STATE, ZIP CODE 90 WEST POPLAR AVENUE OLLIERVILLE, TN 38017		
(X4) ID PREFIX (E/ TAG RE	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
Upon depos within accourprobate estate  This Responsible by: Based review Manage was dedeca reside (Reside of the The firm.  1. Reside there a could accourable refireside there a could accourable related there a could accourable related thema.  During 10/29/2007	the death of ited with the 30 days the nting of those ite jurisdiction.  EQUIREME of on policy region of the facility gement Service of the facility gement Service are sident int's account lent #133, 18, 44 residents addings including view of the facility are no other be a resident int"  View of a physical to [Named of to [Na	a resident with a personal fund facility, the facility must convey resident's funds, and a final a funds, to the individual or administering the resident's RECE NT is not met as evidence of the eview, medical record review, y's "Resident Fund ice Statement" and interview, it a facility failed to refund to the setate the balance of the within 30 days for 3 of 3 and 183) sampled residents included in the stage 2 review.	VED 1 2014	160	Preparation and submission of this plan of correction by, Dove Health and Rehab of Collierville, LLC, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of conclusions set forth on the statement of deficiencies. The plan of correction is prepand submitted solely pursuant to the requirements under state and federal laws.  F 160  1. Monies in resident # 133's trust fund account were distributed to resident # 133's power attorney on 11-19-14 by the Business Office Manager.  Monies in resident # 182's trust fund account were distributed to the State of Tennessee on 19-14 by the Business Office Manager.  Monies in resident # 183's trust fund account were distributed to the resident, which reside in another Long Term Care Facility on 11-1 by the Business Office Manager.  2. On 11-25-14, 31 of 31 resident trust fund who are deceased or discharged greater than days were audited by the business office fur issues were identified at that time.  3. The Business Office Manager was in-served in regards to reimbursement of the balance of resident funds to residents who are deceased discharged from the facility on 11-19-14 by Business Office Coordinator.  4. Beginning the week of 11-23-14, an audit resident's trust fund accounts of residents was are discharged from the facility will be conducted by the Business Office Manager ensure funds are reimbursed. The audits will conducted 3 times weekly for 1 month, wee for 1 month, monthly for 1 month, then quality Assurance Performance Improvement Committee monthly for 3 months. The Administrator will be responsible for monite and compliance.	ount  tot  111-  tot  111-  tot  130  ther  of 3  ho  obe  be  kly  terly  the	(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This sam POL was faxon 11/26/14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' ' '	TIPLE CONSTRUCTION  NG		ATE SURVEY MPLETED
		445495	B, WING		10	)/30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 160	received his refund was discharged to the Expired, he was his did not want his date daughter was in the attorney because he changes. She now his money can be read and the second of the heread had an out then asked if she end discharged to the heread had an out then asked if she end daughter. The BOM certified letter to the When it comes back	why Resident #133 had not. The BOM stated, "Resident he hospital on 9/1/14. If own responsible party and aghter to have his money. His exprocess of getting power of exas having some mental has his power of attorney and efunded back to his daughter."  In the financial office on the BOM was asked why tate had not received her tated, "The resident expired ter was her responsible party of attorney. The resident's	F 11			

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	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		49	TREET ADDRESS, CITY, STATE, ZIP CODE 90 WEST POPLAR AVENUE COLLIERVILLE, TN 38017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 160	10/29/14 at 9:00 Al describe the facility stated, "Refund in a family member that then goes to unclai exists. If the reside attorney, then we contain the statement of the state	ige 2  iew in the financial office on M, the BOM was asked to 's refund policy. The BOM 30 days. We refund to the tis the power of attorney. It med money, but that no longer an send the money back to the	F	160	F 241  1. The three residents who are identified as a dependent on staff for eating were observed Director of Nursing on 10/31/14; no negative outcome identified.  Interviewable residents regarding foley cather privacy, residing on the 300 hall were	by e	
F 241 SS=E	The facility must pr manner and in an e enhances each res	AND RESPECT OF  omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.	F2	241	interviewed by the Director of Nursing on 10 14 to ensure they did not have any signs of mental aguish; no negative issues were identified.  Resident # 10's foley catheter was discontinuon 10-29-14 per physician's orders.  Residents # 18, # 174, and # 180 were provid with fig leaf privacy bags on 10/31/14 by Director of Nursing.	ued	
	by: Based on policy reinterview, it was detreat residents with 24 staff members (Certified Nursing Aresidents requiring "feeder" and failed for 4 of 26 (Reside	NT is not met as evidenced view, observation and termined the facility failed to respect and dignity when 3 of Nurse #1, Nurse #3, and ssistant (CNA) #1) referred to assistance with feeding as a to cover a Foley catheter bag ints #10, 18, 174 and 180) included in the stage 2 review.			2. Beginning on 11-1-14 thru 11-10-14,6 merobservations were conducted by the Register Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursito ensure the staff were using verbiage that is respectful to residents who require assistance with meals; no further negative issues were identified.  On 11-1-14, 5 of 5 residents with foley cathe were audited by the Registered Nurse Supervisor, Staff Development Coordinator, Assistant Director of Nursing, and Minimum Data Set Nurse to ensure privacy was maintained; no further negative issues were identified.	ed ng : : ters	
·	documented, "9. consideration, resp	esident rights policy [The resident] Is treated with sect, and full recognition of his sality, including privacy and in al needs"			3. Beginning on 11-1-14 the nursing staff, including Nurse #1, Nurse #3, and CNA # 1, in-serviced by the Staff Development Coordinator in regards to using verbiage that respectful to residents who require assistance with meals.	is	

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NAME OF I	PROVIDER OR SUPPLIER		······	s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10,	30/2014
DOVE H	EALTH & REHAB OF	COLLIERVILLE, LLC			90 WEST POPLAR AVENUE COLLIERVILLE, TN 38017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(XS) COMPLETION DATE
F 241	2. Observations or 12:51 PM, Nurse #3 3. Observations or 7:45 AM, Nurse #3 [Named Resident] I Observations on the AM, Nurse #3 state Resident] is going to 4. Observations or 7:55 AM, CNA #1 s resident] a feeder." other staff member said.  5. During an interview and an interview and assistance with ADON stated, "No 6. Observations in 10/26/14 at 11:57 At 7:28 AM, revealed bed with a urinary of without a privacy bed without a privacy bed bed in privacy bag 7. Observations in 7. Observations in 10/26/14 at 2:49 Pt stated, "They [staff to be in privacy bag 7. Observations in 10/26/14 at 2:49 Pt stated, "They [staff to be sin privacy bag 7. Observations in 10/26/14 at 11:57	the 300 hall on 10/26/14 at 1 stated, "The rest is feeders."  If the 300 hall on 10/28/14 at asked CNA #2, "Do you have he's going to be a feeder?"  If a 300 hall on 10/28/14 at 8:00 at to CNA #2, "[Named to be a feeder."  If the 300 hall on 10/28/14 at tated, "He's [referring to a There were residents and is in the hall when this was see in the hall when this was see or staff to call residents who the feeding a "feeder". The Ma'am they are not feeders."  Resident #10's room on M, 3:57 PM, and on 10/27/14 at the catheter bag on the bedside ag or cover over the bag.  If in Resident #10's room on M, Resident #10's mother ag or cover over the bag.  If in Resident #10's mother as a said that catheter is suppose and the propose of the propose of the propose of the saident #18's room on the sa	F	241	Beginning on 11-1-14 the nursing staff was in serviced by the Staff Development Coordinate in regards to providing privacy covers to residents with foley catheters.  4. Beginning the week of 11-23-14, meal observations will be conducted by the Register Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursing to ensure staff use verbiage that is respectful residents who require assistance with meals, meal observations will be conducted 3 times weekly for 4 weeks, 1 time a week for 4 week monthly for 1 month, then quarterly thereafter Beginning the week of 11-23-14, an audit of residents with foley catheters will be conducted by the Registered Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursing to ensure foley bags are covered/fig leaf bags are utilized. The audits will be conducted 3 times a week for 4 weeks time a week for 4 weeks, monthly for 1 month then quarterly thereafter.  The results of the meal observations and foley catheter audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The Direct of Nursing is responsible for monitoring and compliance.  Date of Compliance: 11-28-44  F 253  1. On 10-31-14 Maintenance removed the pair splatters from rooms 114 and 120.  On 11-7-14 Housekeeping cleaned the edges corners of the bathroom floor in room 120.  On 10-31-14 Maintenance replaced the commode chair and commode seat in the bathroom of room 124.  On 11-7-14 Housekeeping cleaned the cove by and corners in the bathroom of soon 124.	ered  ag to The  ks, r.  ed  it, l h, y y to  and	
	10/26/14 at 9:00 At	M and 12:35 PM, on 10/27/14 10/28/14 at 8:00 AM, revealed			and corners in the bathroom of room 124.		

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	Continued From pa		F 24	41	On 10-31-14 Maintenance replaced the pourtain and hooks in room 200.	·	
	catheter bag on the or cover over the base of the base	bedside without a privacy bag ag. Resident #174's room on M and 4:09 PM, revealed in the bed with a urinary bedside without a privacy bag			On 10-31-14 Housekeeping cleaned the edges, corners, and cove base of room 20 On 11-10-14 Maintenance cleaned and rethe area behind the commode in the bath room 201.  On 11-10-14 Housekeeping cleaned the corners, cove base, and threshold in the bathroom of room 202.  On 10-31-14 Housekeeping cleaned the chair in room 203.  On 10-31-14 the percutaneous endoscopy gastrostomy syringe and nebulizer mask if 204 were discarded and replaced by direct nursing.	epaired room of dges, wheel	
F 253 SS=E	room on 10/29/14 a asked if she expect covered. The ADON in what we call a Fig should have one, its should a Foley bag 483.15(h)(2) HOUS MAINTENANCE SETTHE facility must promaintenance service sanitary, orderly, and This REQUIREMENT by:  Based on review of and interview, it was to ensure houseked services maintained.	view in the staff development t 7:38 AM, the ADON was ed Foley catheter bags to be I stated, "Yes, they should be g Leaf Bag. All residents is a dignity issue, at no time be exposed to the public." EKEEPING & ERVICES  Existency to maintain a d comfortable interior.  It is not met as evidenced if job descriptions, observation is determined the facility failed reping and maintenance if a clean, sanitary, orderly and ment in residents' rooms as	F 2	53	On 10-26-14 the nutritional supplements if 204 were removed and discarded by direct nursing.  On 10-31-14 Housekeeping cleaned the wabove the bedside, corners, and edges of the bathroom in room 204.  On 10-31-14 Housekeeping cleaned the confide bathroom in room 205.  On 10-31-14 the Housekeeping Supervisor cleaned the corners of room 206.  On 10-4-14 the Housekeeping Supervisor cleaned the edges and corners in the bathroom 208.  On 11-10-14 Maintenance replaced the confider on the floor, and repainted the door facing into the bathroom of room 208.  On 11-5-14 Housekeeping cleaned the conchair over the commode in the bathroom of 208.	or of all ne of 208 of ve spots going	

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F 253	evidenced by mis bathroom floors of corners and under bathroom floors, it substance on the seats, an uncover offensive odors in 124, 200, 201, 20 218, 223, 320, 32  The findings incluing the finding	sing hooks on privacy curtains, irty and with build up in the r sinks, paint splatters on the beeling paint, dried brown toilet seats and wheelchair red nebulizer mask and 17 of 51 (Rooms 114, 120, 2, 203, 204, 205, 206, 208, 216, 4 and 325) resident rooms.  ded:  facility's contracted vices job description cleans floor in residents' room: ops, sweep and disinfects in residents' rooms: Cleans ks, mirrors, pipes; the commode se; then all fixtures, floors, and cleans and disinfects accessary and assigned"  facility's "Housekeeper/Aide Environmental Services" the Housekeeper/Aide Provides within the facility to promote able and homelike environment from the public"	F2	253	On 11-6-14 Housekeeping cleaned the edge corners of room 216.  On 11-6-14 Housekeeping cleaned the edge corners of the bathroom floor in room 218.  On 11-5-14 Housekeeping cleaned the common chair over the commode in the bathroom of 218.  On 11-6-14 the floor in the front of the commof room 223 was repaired by Maintenance.  On 11-11-14 Housekeeping cleaned the cornand edges of the floor in room 320.  On 11-11-14 the cove base of the bathroom in room 324 was cleaned by Housekeeping.  On 11-11-14 the Housekeeping Supervisor cleaned room 325.  The room deodorizers were removed from ro 325 on 10-31-14 by Director of Nursing.  2. On 10-31-14 the Housekeeping Supervisor conducted an audit 51 of 51 resident rooms abathrooms was conducted to ensure the cleanliness of the corners, edges, cove base, walls, and commode chairs; issues identified were addressed at that time.  On 10-31-14 Maintenance was conducted an audit of 51 of 51 resident rooms in regards to paint splatters on the floors, privacy curtain hooks, commode seats, commode chairs over commodes, door facings going into the bathrooms, cove base in the rooms, an areas the wall that have been patched; issues identified will be addressed at that time.  On 10-31-14 an audit of 51 of 51 residents rooms was conducted percutaneous endoscor gastrostomy tube syringes by the Registered Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nursit to ensure proper storage.	s and mode room mode ners floor om nd	

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F 253	chair, paint peeling up on the cove bas  3. Observations or following: a. Room 200 - on 1 curtain had missing the rack. b. Room 201 - on 1 urine, the bathroom around the edges a behind the commod white spackling with musty smell with the 10/26/14 at 12:35 F substance with the wall in bathroom be strong urine odor in 8:27 AM - strong of floor with dirty build corners of the room  During an interview 9:10 AM, Nurse #7 substance on the b Nurse #7 stated, "L. c. Room 202 - on 1 bathroom floor was the edges and in the towel on the floor. bathroom with build the floor and across d. Room 203 - on 10/27/14 at 7:55 A bedside had a drie e. Room 204 - on uncovered Percuta	off the toilet seat, dirty build e in corners of the bathroom.  In the 200 hall revealed the 0/26/14 at 9:10 AM - privacy hooks and was hanging from 0/26/14 at 9:00 AM - Smells of a floor dirty with build up and in the corners, the wall de has been repaired with a black substance and a e appearance of mold. On PM and 3:30 PM - A black appearance of mold on the chind the commode and a the room. On 10/27/14 at fensive odor in the room, the up below cove base and in a the room wall looked like. Looks like mold."  In room 201 on 10/26/14 at was asked what the black eathroom wall looked like. Looks like mold."  10/26/14 at 9:15 AM - the did dirty with dirt build up around the corners with pieces of paper On 10/26/14 at 12:37 PM - the dup around the cove base on s the threshold.  10/26/14 at 4:42 PM and on M - a wheel chair at the diprown substance in the seat.	F2	253	On 10-31-14 an audit of 51 of 51 ronebulizer masks was conducted by the Registered Nurse Supervisor, Staff I Coordinator, and Assistant Director to ensure proper storage.  On 10-31-14 an audit was conducted resident rooms by the Registered Nurse Supervisor, Staff Development Coordinator, Staff Development Coordinator of Nursing to ensurational supplements is not stored bedside.  3. On 11-7-14 the Housekeeping Stain-serviced by the Administrator in cleanliness of the corners, edges, cowalls, and commode chairs.  On 11-10-14 the Housekeepers were by the administrator in regards to the five the corners, edges, cove base, who commode chairs.  On 11-7-14 the Maintenance Superserviced by the Administrator in resplatters on the floors, privacy curt commode seats, commode chairs of commodes, door facings going into bathrooms, cove base in the rooms the wall that have been patched.  On 11-10-14 the Maintenance Asserviced by the Maintenance Direct to paint splatters on the floors, privacy commodes, door facings going into bathrooms, cove base in the rooms, the wall that have been patched.  On 11-20-14 the licensed nurses we by the Staff Development Coordinate to the storage of percutaneous endegastrostomy tube syringes, nebulizar nutritional supplements.	the Development of Nursing of Nursing of Stoff nurse ordinator, some dat the supervisor are in-serving the clean in the cl	was o the iced ness s in-paint s, in s in-gards in r the in viced gards	

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F 253	table, the wall above splatters of yellowis appearance of nutritional supple nebulizer mask under nebulizer mask under nebulizer machine dirty around the edicorner.  f. Room 205 - on 1 floor has dirt build up. Room 206 - on 1 up in the floor in the the wall.  h. Room 208 - on 1 around the edges a in the room. The corner of the wall be had dirt build up arcorner of the floor. paint peeling from bathroom. On 10/2 floor dirty with build the corners, and the commode had drie around the rim.  i. Room 216 - on 1 bathroom floor dirty edges and in the corner j. Room 218 - on 1 bathroom floor dirty edges and in the corner of the floor in front of with dry, liquid stain	the bedside had dried sh brown spots with the itional supplement (6 cans of ement on the bed side table), a covered laying on top of the and the bathroom floor was ges of the wall and in the 0/27/14 at 7:57 AM - bathroom up in the corners. 0/26/14 at 9:25 AM - dirt build a corners of the room along 0/26/14 at 9:30 AM - dirt and in the corners of the floor ove base was missing on the eside the door. The bathroom ound the edges and in the Paint spots on the floor and the door facing going into the 27/14 at 8:05 AM the bathroom up around the edges and in the potty chair over the dirt around the edges and epotty chair over the dirt around the edges and the dirt around the edges and the dirt around the edges and the orners, a potty chair over the dirt around the orners, a potty chair over the dirt around the corners, a potty chair over the dirt around the edges and the orners, a potty chair over the dirt around the orners, a potty chair over the dirt around the orners, a potty chair over the dirt around the orners, a potty chair over the dirt around the orners, a potty chair over the dirt around the orners, a potty chair over the dirt at 8:09 AM and 2:45 PM - the commode in the bathroom	F 2	53	4. Beginning the week of 11-23-14 audits or resident rooms and bathrooms to ensure the cleanliness of the corners, edges, cove base walls, and commode chairs will be conduct the Housekeeping Supervisor. The audits week for 4 weeks, 1 times a week for 4 weeks, 1 times for 4 weeks, 1 times for 4 weeks, 1 times for 1 month, the quarterly thereafter.  Beginning the week of 11-23-14 audits of resident rooms in regards to paint splatters floors, privacy curtain hooks, commode secommode chairs over the commodes, door facings going into the bathrooms, cove bas the rooms, an areas in the wall that have be patched will be conducted by the Maintena Supervisor. The audits will be conducted 3 a week for 4 weeks, 1 times a week for 4 weeks for 4 weeks, 1 times a week for 4 weeks for 11-23-14 audits of percutaneous endoscopy gastrostomy tube syringes will be conducted by the Registere Nurse Supervisor, Staff Development Coordinator, and Assistant Director of Nur to ensure proper storage. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4	ed by vill be me a en on the ats, e in sen nce times vecks, eter.  ed sing mes a en	

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F 253	following: a. Room 320 - on 1 bathroom floor had and the corners. b. Room 324 - on 1 build up around the floor. c. Room 325 - on 1 PM, on 10/27/14 at 8:15 AM - very stro There were 6 room was on the shelf be and 5 were on a tal in the A bed.  During an interview 6:25 PM, the house questioned about ti The housekeeping everything with [poi it is him, he will not assistants [CNAs] of mattress when can housekeeping supe odor in room 325.  During an interview 6:35 PM, CNA #4 refuses care freque me care for him, bu have had difficulty care."  5. During an interview and 300 halls on 16 administrator was a housekeeping and	0/27/14 at 3:16 PM - dirt build up around the edges 0/26/14 at 3:53 PM - dirty cove base on the bathroom 0/26/14 at 12:48 PM and 4:25 2:57 PM, and on 10/28/14 at ng offensive odor in the room. deodorizers in this room, 1 eside the resident in the A bed, I shelf in front of the resident in room 325 on 10/27/14 at exceping supervisor was ne odor in this resident's room. supervisor stated, "Have tried nting to resident in the A bed], always let the certified nursing clean him, try to clean his don't know what to do." The ervisor confirmed there was an of in room 325 on 10/28/14 at confirmed there was an odor in stated, "He [named resident] ently, he is incontinent, will let ut he refuses to be cleaned up, with this resident refusing	F	253	at the bedside. The audits will be conducted times a week for 4 weeks, 1 times a week for weeks, monthly for 1 month, then quarterly thereafter.  The results of the audits will be reviewed by Quality Assurance Performance Improvemer Committee monthly for 3 months. The Administrator is responsible for monitoring a compliance.  Date of Compliance: 11-28-14	the	11- 28-14

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	PROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 190 WEST POPLAR AVENUE COLLIERVILLE, TN 38017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 253 F 279 SS=D	his head in confirmation 483.20(d), 483.20(d), 483.20(d). 483.20(d). COMPREHENSIVE A facility must use to develop, review a comprehensive plan. The facility must deplan for each reside objectives and time medical, nursing, a needs that are identificated assessment.  The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any so be required under §483.10, including funder §483.10, including funder §483.10(b)(4). This REQUIREMED by:  Based on policy reand interview, it was to develop a plan of and interventions to for 1 of 23 (Resider reviewed of the 44).	ation. (A)(1) DEVELOP E CARE PLANS The results of the assessment and revise the resident's nof care. Evelop a comprehensive care ent that includes measurable stables to meet a resident's not mental and psychosocial tified in the comprehensive  It describe the services that are attain or maintain the resident's physical, mental, and reing as required under ervices that would otherwise (483.25 but are not provided is exercise of rights under the right to refuse treatment	F 253		rise lities  rise lities  cities cd lities  cd lities
,	2 review. The findings include	ed:			į

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		E SURVEY IPLETED
		445495	B. WING			10/	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		490 W	T ADDRESS, CITY, STATE, ZIP CODE EST POPLAR AVENUE JERVILLE, TN 38017	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 279	Review of the facilit documented, "It is to develop and maintain resident upon admirplans at least quarted Care Plan includes timetables to meet the nursing, psychologic identified in the Core Medical record revied documented an admirate diagnoses of Anemi Hypertension, Non-Anxiety, Depression Chronic Lung Diseas Morbid Obesity, Pul Tracheostomy, Gast Hypoventilation Synthesis (MDS) with an asset of 6/18/14 document of the black MDS with an ARD of Resident #126 as obladder (less than 7). Review of the "Resident #126 with bladder.  Review of the care idocumented, "req ADL's contineent	y's care plan policy he policy of this facility to in a Plan of Care for each ssion and to review such erly Each Comprehensive measurable goals and the resident's medical, cal, and social needs that are inprehensive Assessment"  ew for Resident #126 inission date of 8/13/14 with a, Heart Failure, Diabetes, Alzheimer's Dementia, in, Asthma, Respiratory Failure, ise, Obstructive Sleep Apnea, monary Embolism, troparesis, Dementia and drome.  ession Minimum Data Set ssment reference date (ARD) and the desident #126 as always and the desident #126 as always and the casionally incontinent of the depisodes of incontinent of the dep	F 2	79			

PRINTED: 11/17/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	COME	PLETED
		445495	B. WING			10/3	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		4	TREET ADDRESS, CITY, STATE, ZIP CODE 90 WEST POPLAR AVENUE OLLIERVILLE, TN 38017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280 SS=D	During an interview station on 10/29/14 Coordinator was as incontinence. The I there was no care stated, "I don't see will have to add that 483.20(d)(3), 483.1 PARTICIPATE PLATE The resident has the incompetent or oth incapacitated under participate in plann changes in care and A comprehensive as interdisciplinary teat physician, a register for the resident, and disciplines as determined to the extent purchase in the resident, the resident in	in front of the 300 hall nurses' at 3:10 PM, the MDS sked about a care plan for MDS Coordinator confirmed plan for incontinence, and a care plan for incontinence, at."  10(k)(2) RIGHT TO NNING CARE-REVISE CP he right, unless adjudged erwise found to be in the laws of the State, to ing care and treatment or		280	1. Resident # 64 was re-evaluated on 11-11-14 by the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Nurse, Activities Director, and Social Services in regards to fall risk and the use of the bed an chair alarms. Resident # 64's attending physic was notified on 11-11-14 by the Director of Nursing and new orders were received to discontinue the bed alarm. After Interdisciplin Team review on 11-11-14, resident #64's chair alarm was removed and resident # 64's care plaws revised at that time.  2. On 11-24-14 the Director of Nursing conducted an audit of 20 of 20 incidents/ accident reports from the past 90 days to ensure fall interventions were added to the resident's care plan; no further issues were identified at time.  On 11-3-14, 7 of 7 residents were observed by the Director of Nursing and Assistant Director Nursing to ensure residents with interventions for bed or chair alarms had the alarms intact. addition, the care plans of residents with interventions for bed or chair alarms were audited at this time; no further issues were identified.  On 11-3-14 7 of 7 residents with interventions bed and chair alarms were audited to ensure the resident's Medication Administration Records indicated to check placement and functioning each shift by the assistant director of nursing issues identified were addressed at that time.	Set  Set  Set  Set  Ser  Ser  Ser  Ser	
	by: Based on policy re report, medical rec interview, it was de	NT is not met as evidenced eview, review of an incident cord review, observation and etermined the facility failed to the care plan for falls for 1 of					

Facility ID: TN7941

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l''		E CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER EALTH & REHAB OF	COLLIERVILLE, LLC		49	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST POPLAR AVENUE DLLIERVILLE, TN 38017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 280	23 (Resident #64) residents included The findings included The potential for the potential for might contribute to those factors idented for falls PROCE fallen in the past reconsidered at high score 4. The care a fall to address the fall"  Medical record reductmented an addiagnoses of Malid Depressive Disord Late Effects of Cestate and Lack of Review of the nurreductmented, " Review of the nurreductmented, " Review of an incided documented, " In position of resident What did resident get back into bed' INCIDENT what Resident attempts wheelchair without during or immedia	sampled residents of the 44 I in the stage 2 review.  ded:  lity's falls policy documented, of this facility to assess residents or falls and identify factors that to falls. The facility will address tified in order to reduce the risk DURE 3. If the resident has month, the resident will be a risk regardless of their risk re plan should be updated after the most recent cause of the view for Resident #64 dmission date of 11/23/10 with gnant Neoplasm of the Colon, der, History of Fall, Joint Pain, prebrovascular Accident, Anxiety	F	280	3. On 11-20-14 the members of the Interdisciplinary Team (Director of Nursing Assistant Director of Nursing, Registered N Supervisor, Minimum Data Set Nurse, Activ Director, and Social Services) were in-servi by the Regional Clinical Re-imbursement N in regards to the development and revisions comprehensive care plans.  Beginning on 11-18-14 the licensed nurses in-serviced by the Staff Development Nurse Director of Nursing in regards to revising the resident's care plan with new fall reduction interventions.  4. Beginning the week of 11-23-14 audits of resident care plans who have sustained a fall be audited by the Minimum Data Set Nurse Registered Nurse Supervisor, and/or Assis Director of Nursing to ensure care plans habeen revised with fall reduction intervention. The audits will be conducted 3 times a week 4 weeks, 1 times a week for 4 weeks, mont for 1 month, then quarterly thereafter.  Beginning the week of 11-23-14 audits of residents with interventions for bed and/or alarms will be assessed to ensure the alarm intact and functioning. The audits will be conducted by the Minimum Data Set Nurse Registered Nurse Supervisor, and/ or Assis Director of Nursing. The audits will be conducted 3 times a week for 4 weeks, 1 times a week for 4 wee	furse vities ced furse ced furse of were and se furse and se furse cons. sk for stant ave ons. sk for ship furse chair furse cons. stant ave ons. sk for ship furse cons. stant ave ons. sk for ship furse cons. sk for ship furse cons.	11- 28-14

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''				E SURVEY PLETED
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	COLLIERVILLE, LLC		4	90 WEST POPLAR AVENUE	1 101	00/2017
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
and to prevent future Reeducated on call Review of the nurse documented, "Reget back in bed into educated several nurse re-educated retransfers"  Review of a care pladocumented, "Pro Approaches Bed a unassisted transfers Re-educate R/T [refassistance"  Observations in Reat 8:15 AM, reveale back, a clip alarm we clip part of the alarm connected to the rehanging under the beconnected.  The facility did not in on the care plan aft.  During an interview on 10/30/14 at 11:4 (MDS) coordinator was initiated. "I'm not seeing whe usually write an ord has a history of falls MDS coordinator was initiated."	light and chair alarm"  es' notes dated 10/21/14 sident states 'I was trying to bed.' Resident has been times on safety issues. This resident on safety issues and an dated 11/23/10 oblem at risk for falls alarm to alert staff of s call light use 10/21/14 lated to] asking for transfer  sident #64's room on 10/28/14 of Resident #64 in bed on her was on the side rail with the in hanging down and not sident. There was an alarm bed and that alarm was not  mplement a new intervention er the fall on 10/21/14.  in the staff development room 5 AM, the Minimum Data Set was asked when the chair The MDS Coordinator stated, are it was ordered. They er for it. She [Resident #64] is I can look in overflow." The as asked, should the	F 2	?80			
			į			
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa and to prevent futur Reeducated on call  Review of the nurse documented, "Re get back in bed into educated several nurse re-educated in transfers"  Review of a care ple documented, "Pro Approaches Bed in unassisted transfers Re-educate R/T [ref assistance"  Observations in Ref at 8:15 AM, reveale back, a clip alarm w clip part of the alarm connected to the re hanging under the b connected.  The facility did not i on the care plan aft  During an interview on 10/30/14 at 11:4 (MDS) coordinator alarm was initiated. "I'm not seeing whe usually write an ord has a history of falls MDS coordinator w wheelchair alarm be The MDS coordinator w wheelchair alarm be The MDS coordinator The MDS coordinator w wheelchair alarm be The MDS coordinator	### A45495  PROVIDER OR SUPPLIER  EALTH & REHAB OF COLLIERVILLE, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13 and to prevent future recurrences of this incident? Reeducated on call light and chair alarm"  Review of the nurses' notes dated 10/21/14 documented, "Resident states 'I was trying to get back in bed into bed.' Resident has been educated several times on safety issues. This nurse re-educated resident on safety issues and transfers"  Review of a care plan dated 11/23/10 documented, "Problem at risk for falls Approaches Bed alarm to alert staff of unassisted transfers call light use 10/21/14 Re-educate R/T [related to] asking for transfer assistance"  Observations in Resident #64's room on 10/28/14 at 8:15 AM, revealed Resident #64 in bed on her back, a clip alarm was on the side rail with the clip part of the alarm hanging down and not connected to the resident. There was an alarm hanging under the bed and that alarm was not	A BUILD  445495  RECORRECTION  445495  B. WING  PROVIDER OR SUPPLIER  EALTH & REHAB OF COLLIERVILLE, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13  and to prevent future recurrences of this incident? Reeducated on call light and chair alarm"  Review of the nurses' notes dated 10/21/14 documented, "Resident states 'I was trying to get back in bed into bed.' Resident has been educated several times on safety issues. This nurse re-educated resident on safety issues and transfers"  Review of a care plan dated 11/23/10 documented, "Problem at risk for falls Approaches Bed alarm to alert staff of unassisted transfers call light use 10/21/14 Re-educate R/T [related to] asking for transfer assistance"  Observations in Resident #64's room on 10/28/14 at 8:15 AM, revealed Resident #64 in bed on her back, a clip alarm was on the side rail with the clip part of the alarm hanging down and not connected to the resident. There was an alarm hanging under the bed and that alarm was not connected.  The facility did not implement a new intervention on the care plan after the fall on 10/21/14.  During an interview in the staff development room on 10/30/14 at 11:45 AM, the Minimum Data Set (MDS) coordinator was asked when the chair alarm was initiated. The MDS Coordinator stated, "If m not seeing where it was ordered, They usually write an order for it. She [Resident #64] has a history of falls. I can look in overflow." The MDS coordinator was asked, should the wheelchair alarm be included on the care plan. The MDS coordinator stated, "If there was an	### A BUILDING  ### A SUPPLIER  ### A SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  #### Continued From page 13  ### and to prevent future recurrences of this incident? Reducated on call light and chair alarm"  ### Review of the nurses' notes dated 10/21/14 documented, "Resident states 'I was trying to get back in bed into bed.' Resident has been educated several times on safety issues. This nurse re-educated resident on safety issues and transfers"  ### Review of a care plan dated 11/23/10 documented, "Problem at risk for falls Approaches Bed alarm to alert staff of unassisted transfers call light use 10/21/14 Re-educate R/T [related to] asking for transfer assistance"  *### Observations in Resident #64's room on 10/28/14 at 8:15 AM, revealed Resident #64 in bed on her back, a clip alarm was on the side rail with the clip part of the alarm hanging down and not connected to the resident. There was an alarm hanging under the bed and that alarm was not connected.  The facility did not implement a new intervention on the care plan after the fall on 10/21/14.  During an interview in the staff development room on 10/30/14 at 11:45 AM, the Minimum Data Set (MDS) coordinator was asked when the chair alarm was initiated. The MDS Coordinator stated, "I'm not seeing where it was ordered. They usually write an order for it. She [Resident #64] has a history of falls. I can look in overflow." The MDS coordinator was asked, should the wheelchair alarm be included on the care plan. The MDS coordinator stated, "If there was an Included on the care plan. The MDS coordinator stated, "If there was an	### A BUILDING   B. WING    ### A BUILDING    ### BUILDING    ### A BUILDING    ### BUILDING    ##	A BUILDING  445495  ROWIDER OR SUPPLIER  A REHAB OF COLLIERVILLE, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  CONTINUED From page 13  and to prevent future recurrences of this incident? Reeducated on call light and chair alarm"  Review of the nurses' notes dated 10/21/14 documented, "Resident states" I was trying to get back in bed into bed. 'Resident states' I was trying to get back in bed on her back, a clip alarm was on the side rail with the clip part of the alarm hanging down and not connected to the resident. There was an alarm hanging under the bed and that alarm was not connected to the resident. There was an alarm hanging under the bed and that alarm was not connected to the resident. There was an alarm hanging under the bed and that alarm was not connected to the resident was ordered. The MDS coord

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION MUMPED:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445495	B. WING			10/:	30/2014
DOVE H		COLLIERVILLE, LLC	ID	49	TREET ADDRESS, CITY, STATE, ZIP CODE 30 WEST POPLAR AVENUE OLLIERVILLE, TN 38017 PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
F 282 SS=D	orders and the inci [Director of Nursing and reviews the int term interventions by for the care plar wheelchair alarm u check and let you i  During an interview on 10/30/14 at 12: stated, "I spoke wit chair alarm don't n nursing intervention was here when she that the chair alarm fall [10/21/14]." The if a chair alarm is ii the care plan. The the intervention sh- surveyor again ask initiated. The MDS 10/21/14 after that the chair alarm wa- nurses notes. The not know, will have further explanation 483.20(k)(3)(ii) SE PERSONS/PER C. The services provi- must be provided to accordance with ea- care.  This REQUIREME by:	dent reports after the DON g) looks at the incident report gerventions. The DON puts long in place and that is what we go n. I can't find the order for the unless it is in overflow I will know."  In the staff development room to PM, the MDS coordinator the DON and she said the eed an order because it is a n. I spoke with the nurse that the had the fall and she told me n was put on when she had the the MDS coordinator was asked the was put on when she had the the MDS coordinator confirmed ould be on the care plan. This the when the chair alarm was coordinator stated it was fall. This surveyor asked why s documented in the 5/1/14 MDS coordinator stated, "Do to check in overflow." No was ever provided. RVICES BY QUALIFIED		280	F 282  1. Resident # 64 was re-evaluated on 11-11-14 by the Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Registered Nurse Supervisor, Minimum Data Nurse, Activities Director, and Social Services in regards to fall risk and the use of the bed an chair alarms. Resident # 64's attending physic was notified on 11-11-14 by the Director of Nursing and new orders were received to discontinue the bed alarm. After Interdisciplin Team review on 11-11-14 resident #64's care plass was revised at that time.  Resident # 164's care card was revised on 11-14 by staffing development coordinator to refresident # 164's oral care status and request from the staffing development coordinator to refresident # 169's Medication Administration Record was revised on 11-1-14 by staffing development coordinator to reflect the need for checking placement and functioning of the bealarm and chair alarm.	Set s) d d d d d d d d d f d f f f f f f f f	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1`'		E CONSTRUCTION		TE SURVEY MPLETED
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F 282	interview, it was de follow care plan intra and follow the care Living (ADLS) assis #64, 164 and 169) residents included. The findings included an address to reduce the PROCEDURE 3. past month, the reshigh risk regardless care plan should be address the most reduced an addiagnoses of Malig Depressive Disorded Late Effects of Censtate and Lack of Censtate and Lac	ecord review, observation and termined the facility failed to erventions for bed and chair care plan interventions for falls plan for Activities of Daily stance for 3 of 23 (Residents sampled residents of the 44 in the stage 2 review.  ed:  dility's falls policy to be the policy of this facility to be the potential for falls and might contribute to falls. The those factors identified in risk for falls  If the resident has fallen in the sident will be considered at the of their risk score 4. The end updated after a fall to be event cause of the fall"  Teview for Resident #64 mission date of 11/23/10 with mant Neoplasm of the Colon, er, History of Fall, Joint Pain, ebrovascular Accident, Anxiety Coordination.  Ian dated 11/23/10 oblem at risk for falls alarm to alert staff of	F	282	2. On 11-3-14 11 of 11 residents were ob by the Director of Nursing and Assistant Director of Nursing to ensure residents winterventions for bed or chair alarms were In addition, the care plans of residents winterventions for bed or chair alarms were audited at this time; no further issues were identified.  On 11-24-14 the Director of Nursing cor an audit of 20 of 20 incidents/ accident refrom the past 90 days to ensure fall intervence added to the resident's care plan; no issues were identified at that time.  On 11-19-14 an audit of 100 of 100 residence cards were audited by the staff devel to ensure the reflection of oral care status any special request made by the residents morning care; issues identified were addit that time.  On 11-1-14, 7 of residents of 7 residents interventions for bed and chair alarms we audited to ensure the resident's Medicatic Administration Records indicated to cheplacement and functioning each shift by Assistant Director of Nursing and RN supervisor; issues identified were address that time.  3. Beginning on 11-19-14 the Staff Deve Coordinator in-serviced nursing staff in to the revision and the following of the recare plan and care card for Activities of 1 Living, and the following care plans and cards for placement of chair and bed alar implementation of interventions to reduc potential of falls. Licensed nurses were it serviced in regards to adding intervention chair and bed alarms to the resident's Me Administration Record to ensure placeme functioning are checked each shift.	rith c intact. th e e e  inducted cports centions o further  dent's lopment s and s for ressed at  with cre on ck  sed at  lopment regards csident's Daily care rems, e e n- ns for edication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445495	B, WING			10/	30/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
DOVE H	EALTH & REHAB OF	COLLIERVILLE, LLC			00 WEST POPLAR AVENUE OLLIERVILLE, TN 38017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	38 C	(X5) COMPLETION DATE
F 282	connected to Resid hanging under the connected.  Observations in Re at 2:50 PM, revealed wheelchair at bedsi hanging on the bed to Resident #64.  Observations in the 3:45 PM, revealed wheelchair. There wheelchair. There wheelchair. There wheelchair or The facility was not interventions for ala During an interview 10/28/14 at 3:00 PM (CNA) #6 was asked connected to the rema'am. I just took if #6 was then asked resident. CNA #6 sther when she is up. During an interview 10/28/14 at 8:20 Afthere were 2 alarm: Nurse #5 stated, "I at the alarms. Nurse the alarm, they ta when she is up." Not there was an alarm Nurse #5 stated, "T sensor on the mattithe sensor alarm when she is up."	ent #64. There was an alarm ped and that alarm was not sident #64's room on 10/28/14 at Resident #64 sitting up in a de. There were 2 alarms rail and neither was attached at therapy room on 10/28/14 at Resident #64 sitting in her was no alarm on Resident clipped to her.	F	282	4. Beginning the week of 11-23-14 audits or residents with interventions for bed and/or alarms will be assessed to ensure the alarm intact and functioning. The audits will be conducted by the Minimum Data Set Nurse Registered Nurse Supervisor, and/ or Assis Director of Nursing. The audits will be conducted 3 times a week for 4 weeks, 1 times week for 4 weeks, 1 times a week for 4 weeks, month for 1 month, then quarterly thereafter.  Beginning the week of 11-23-14 3 resident's cards will be audited to ensure they indicate resident's oral status, Activities of Daily Livitatus, and any special request made by the resident for morning care. The audits will be conducted by the Minimum Data Set Nurse, Registered Nurse Supervisor, and/ or Assist Director of Nursing. The audits will be conducted 3 times a week for 4 weeks, 1 times a week	chair is tant nes a n l will ant e s. for ly s care the ting with e stant cted of tes a cs, er. the nt ttor	11- 28-14
	67/02-00) Provious Versions		1	Faci		tion sheat	Page 17 of 59

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		E SURVEY PLETED
		445495	B. WING			10/:	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		49	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST POPLAR AVENUE OLLIERVILLE, TN 38017		
(X4) JD PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC !DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	8E	(X5) COMPLETION DATE
F 282	alarms were doing connected. Nurse #  3. Medical record r documented an adr diagnoses of Menin Ataxia, Hypertensio Cardiac Dysrhythm Cardiomyopathy.  Review of the adminassessment referer documented a Brief (BIMS) score of 9 in was moderately imprequired extensive a hygiene including buthe 30 day MDS with date of 10/4/14 doc BIMS score of 15 in cognitively intact for required extensive a hygiene including buthe 30 day MDS with date of 10/4/14 doc BIMS score of 15 in cognitively intact for required extensive a hygiene including buthe 30 day MDS with date of 10/4/14 doc BIMS score of 15 in cognitively intact for required extensive a hygiene including buther and care Approach Do not rush Allow as needed Assist and other ADLs as daily and PRN [as review of initial nur documented, "Da [checked] Use so [checked] Use mound Review of a "CNA (CNA).	any good since they were not stated, "No ma'am."  eview for Resident #164 mission date of 9/8/14 with gioma, Pulmonary Collapse, n, Hernia, Hypothyroidism, ia, Hyperlipidemia and Primary ssion MDS with an noce date of 9/15/14 Interview for Mental Status adicating the Resident #164 paired for decision making and assistance for personal rushing her teeth. Review of h an assessment reference umented Resident #164 was decision making and assistance for personal rushing her teeth.  and dated 9/22/14 documented, e assist of ADL's including thes Assist as needed extra time to complete ADLs with bathing, grooming needed Provide oral care	F2	82			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3	3) DATE SURVEY COMPLETED
		445495	B. WING	;		10/30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		STREET ADDRESS, CITY, STATE, ZIP 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE EAPPROPRIAT	
F 282	STATUS ORAL CASSISTED Total Canot checked to indicate oral care.  Observations in Ref 10/26/14 at 12:39 F Resident #164's rocall light. Resident she wanted a warm face and before shourse turned arount to leave the room usurveyor that the reher. The staffing nubedside and asked needed.  During an interview 10/26/14 at 12:39 F if she received the her teeth. Resident need my toothbrush Resident #164 was teeth/dentures clear "Twice a week may During a discussion (DON) on 10/26/14 informed of an incidence of the surveyor was given a shand the diaper was shower was completed to the surveyor was completed and a toothbrush and the diaper was shower was completed and a toothbrush canon at a toothbr	DESCRIBE RESIDENT'S CARE Independent Ire" The oral care area was cate the resident's status for  PM, the staffing nurse came in om answering Resident #164's #164 was telling the nurse that a soapy wash cloth to wash her e could finish telling the nurse a swabs for her mouth, the d and walked toward the door intil she was told by this esident was still trying to talk to urse then returned to the what else the resident  In Resident #164's room on PM, Resident #164 was asked help necessary for cleaning #164 stated, "I can do it, but I in and a soapy wash cloth."  asked how often are your ned. Resident #164 stated,	F 2	282		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION  NG		X3) DATE SURVEY COMPLETED
		445495	B. WING			10/30/2014
	ROVIDER OR SUPPLIER	COLLIERVILLE, LLC		STREET ADDRESS, CITY, STATE, ZIP ( 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B	
F 282		ge 19 ported to the surveyor on	F 2	82		
	that was provided be an investigation for with a diaper on, the	of concern dated 10/26/14 by the DON only documented the concerns of being bathed ere was no documented concerns related to requesting oth brush.				
	10/28/14 at 9:50 AN want a warm soapy and hands. I ate bre sticky and I would li if they would just br cloth. I asked for or have any up here yof those little good to your mouth I could good." Resident #10	in Resident #164's room on M, Resident #164 stated, "I wash cloth to wash my face eakfast and my fingers are ke to wash my face. I can do it ing me a warm soapy wash be but they told me they didn't et. If I could get that and some easting sticks that you put in wipe my teeth off and I will be 64 was asked if she had her his morning. Resident #164				
	dining room on 10/2 was asked if she was CNA #5 stated, "Ye I have had her." CN knows what she is a #164 if she hasn't to CNA #5 stated, "I to taken care of her at CNA care card]." Count the care card and it bathing, if that mean own bath and you ju #5 stated, "I do it for	in the 200 hall beside the 28/14 at 10:05 AM, CNA #5 as assigned to Resident #164. s, but this is only the 2nd time IA #5 was asked how she supposed to do for Resident aken care of her that much. alk to the other CNAs that have nd we have this [indicating a NA #5 was asked if I look at is marked supervision for ns the resident can do her ust have to set up for her. CNA r her." CNA #5 was asked w what to do for her mouth	: !			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[ · ·	TIPLE CONSTRUCTION	l (		E SURVEY PLETED
		445495	B. WING	<u></u>	ľ	10/:	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017	DDE	101	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD E		(X5) COMPLETION DATE
F 282	"You wouldn't know #5 stated, "The CN, care. She gets it da already up, I keep hher face, bathe her During an interview on 10/28/14 at 3:20 she had addressed #164 related to her her tooth brush in the "No, I have not. I was other issue, but I will During an interview on 10/28/14 at 3:55 where the CNAs do is done. The DON seach floor that they have 2 on each flood. Medical record in documented an addresses of Gastro Failure, Diabetes Malzheimer's Disease Review of the care documented, "Ris falls bed/chair ala	is marked. CNA #5 stated, how to do mouth care." CNA A before me gives her mouth illy." CNA #5 stated, "If she is her dry. If she is not up I wash and put her clothes on."  in the staff development room PM, the DON was asked if the concerns from Resident not receiving a wash cloth or the mornings. The DON stated, as more concerned with the II."  in the staff development room PM, the DON was asked cument their ADL care when it stated, "They have a book on document this in I think they wr."  eview for Resident #169 mission date of 10/09/14 with bintestinal Hemorrhage, Heart lellitus, Hyperlipidemia and	F 2				
	(MARS) for Octobe Alarm, Chair Alarm I bilateral Bed 7A -	cation Administration Record r 2014 documented, "Bed Landing strips Applied to 7P 7P-7A" There was no essing that the bed and chair ng or in place.		· · · · · · · · · · · · · · · · · · ·			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
		445495	B. WING		·	10/:	30/2014
	ROVIDER OR SUPPLIER	COLLIERVILLE, LLC		49	TREET ADDRESS, CITY, STATE, ZIP CODE 90 WEST POPLAR AVENUE OLLIERVILLE, TN 38017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 SS=D	on 10/28/14 at 5:30 how does she checked and chair alarm my hand on the pacchair and raise my? Nurse #2 was aske it was checked. Nurse #2 was aske it was checked. Nurse wery shift."  During an interview on 10/28/14 at 5:45 view the MARS who and chair alarm was #3 stated, "Here [point is supposed to be was no documentate functioning was bei 483.25 PROVIDE OF HIGHEST WELL BIT Each resident must provide the necession maintain the high mental, and psychological provides with the and plan of care.  This REQUIREMED by:  Based on policy reobservation and intending failed to provide the provide the necession maintain the high mental, and psychological provides with the and plan of care.	at the 300 hall nurses' station PM, Nurse #2 was asked k placement and function of hs. Nurse #2 stated, "I just put d where it is on the bed or the hand up and it should alarm. d where is it documented that rse #2 stated, "On the MARS at the 300 hall nurses' station PM, Nurses #3 was asked to be re it was documented the bed is checked every shift. Nurse binting at the MARS] is where he will be will be will be in the placement and any assessed, as care planned. CARE/SERVICES FOR EING are ceive and the facility must arry care and services to attain the placement and he st practicable physical, associal well-being, in the comprehensive assessment.		309	F 309  1. Resident # 128 was discharged from the facility on 06-19-14.  Resident # 173 was discharged from the facilion 11-3-14.  2. Beginning on 11-3-14 the Medical Records Nurse conducted an audit of 83 of 83 resident Medication Administration Records who have been discharged within the past 3 months; no further issues were identified.	s 's e	
		physician ordered medications assessment for 2 of 23					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	F ' '		E CONSTRUCTION		E SURVEY PLETED
		445495	B. WING	·		10/	30/2014
	PROVIDER OR SUPPLIER  EALTH & REHAB OF (	COLLIERVILLE, LLC	ID	49	REET ADDRESS, CITY, STATE, ZIP CODE 00 WEST POPLAR AVENUE OLLIERVILLE, TN 38017 PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE
F 309	reviewed for medicincluded in the stage.  The findings included in the stage.  1. Medical record of documented an addiagnoses of Obstraction, Chronic Respiratory. Dysphagia, Speech Tobacco Use Disord.  Review of the physion of the	ad 173) sampled residents ation use of the 44 residents ation use of the 44 residents at 2 review.  ed:  eeview for Resident #128 mission date of 5/27/14 with active Chronic Bronchitis with nic Airway Obstruction, and Language Disorder and der.  ician admission orders dated d., "Flucanazole 200 mg.  [by mouth] QD [every day]  ng / [every] 24 [sign for hours]  Nystatin 100,000 units / ml on take 5 ml po QID [four times are 20 mg i po Q AM sone 10 mg i po QD  co QID Amlodopine 2.5 MG i	F	309	Beginning on 11-25-14 the Assistant Dire of Nursing conducted an audit of 52 of res of 52 resident's pain management flow rewho are receiving pain medication to ensu documentation of the resident's pain rating method used to relieve the pain, and the reassessment of the pain rating after the intervention was provided; issues identifie addressed at that time.  3. Beginning the week of 11-25-14 the Dir of Nursing and Staff Development Coordinin-serviced the Medical Records Nurse, M. Records Assistant, and the licensed nurses process of removing and filing the Medical Administration Records of discharged residences of nurses in regards to the documents of the resident's pain ratings, the method us relieve the pain, and the reassessment of the rating after the intervention is provided on resident's pain management flow record.  4. Beginning the week of 11-23-14, 3 clinic records of residents who have been discharfrom the facility will be audited by the Med Records Nurse and/or Medical Records Asside ensure the resident's most recent Medical Administration Records are filed in the clos record. The audits will be conducted weekly 4 weeks, then monthly for 3 months and quarterly thereafter.  Beginning the week of 11-23-14, 3 resident management flow records will be audited by Registered Nurse Supervisor, Assistant Dire of Nursing, and/or Staff Development Coordinator to ensure documentation reflect resident's pain ratings, the method used to relieve the pain, and the reassessment of the rating after the intervention is provided. The audits will be conducted weekly for 4 weeks then monthly for 3 months, then quarterly thereafter.	idents cords re the sords re the sp, the d were ector nator edical on the cion dents.  Attion sed to e pain the sed re pain ed re for sp pain et the cord sp pain et the pain et the pain et the sp pain et the cord sp pain et the pa	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility (D: TN7941

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED	
		445495	B. WING			1	0/30/2014
	PROVIDER OR SUPPLIER EALTH & REHAB OF	COLLIERVILLE, LLC		490	EET ADDRESS, CITY, STATE, ZIP CODI WEST POPLAR AVENUE LLIERVILLE, TN 38017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	policy documented, to screen residents indicated for cause what relieves the pareceive treatment for then monitored for 0- [to] 10 (0 = [mean should be utilized for Medical record revided documented an addiagnoses of Conge Hypertension, Hyperof the Lower Left Left Review of the cogni 10/16/14 document were consistent and make himself under memory problems, impairment.  Review of the admit 10/16/14 document in the past 5 days wand severe and what 10/325 milligrams (for the surface of the screen what 10/325 milligrams (for the screen what 10/325 milligrams (fo	"It is the policy of this facility for pain and further assess if and severity of pain as well as ain. All residents should or pain relief as warranted and effectiveness A pain scale of ins] no pain, 10 = worst pain) or the adult resident"  ew for Resident #173 mission date of 10/16/14 with estive Heart Failure, or ipidemia and Venous Ulcer and Left Inner Ankle. It ive performance scale dated ed the resident's decisions direasonable, was able to restood, had no short-term and had no cognitive sesion pain assessment dated ed the resident's pain intensity was rated between moderate at relieved the pain was Lortab mg).	F3	09	The results of the audits will be review Quality Assurance Performance Impro Committee monthly for 3 months. The of Nursing is responsible for monitoric compliance.  Date of Compliance: 11-28-14	Director	11- 28-14
	flow sheet part of the Sheet (MAR), for O assessment of the method used to reli	e pain rating after the			·		
	documented the res	an's order dated 10/16/14 sident was to be given the pain 10/325 mg (10 mg of 25 mg of acetaminophen) one			•		

PRINTED: 11/17/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		445495	B. WING		<del> </del>	10/	30/2014
	SUMMARY STA	COLLIERVILLE, LLC  ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	490 CO x	REET ADDRESS, CITY, STATE, ZIP CODE WEST POPLAR AVENUE LLIERVILLE, TN 38017  PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 311 SS=D	by mouth every 6 h for pain control. Th dated 10/23/14 incitorab to every 4 h uncontrolled pain.  During an interview 10/27/14 at 8:40 Al Lortab 10/325 relie  During an interview on 10/29/14 at 10:10 (DON) was asked, documenting the alof a resident's pain indicated the resides should be recorded flow sheet.  483.25(a)(2) TREA IMPROVE/MAINTA A resident is given services to maintail specified in paragrametric or maintail specified in paragrametric or concern, obtained the fact with Activities of Date (Resident #164) sa residents who were the findings included the find	ours as the resident needed e wound specialist's order reased the frequency of the ours as needed due to in Resident #173's room on M, Resident #173 stated ves his pain.  In the staff development room 10 AM, the Director of Nursing if the nurses should be seessment and reassessment. The DON stated, "Yes" and ent's pain documentation on the "pain management and nor improve his or her abilities aph (a)(1) of this section.  NT is not met as evidenced record review, review of a servation, and interview, it was sillity failed to provide assistance ally Living (ADLS) for 1 of 2 ampled residents of the 10 e interviewed about ADLS.	F3	311	1. Resident # 164's care card was revised o 19-14 by staffing & development coordinat reflect resident # 164's oral care status and request for a warm, soapy wash cloth in the morning to perform facial and hand hygient 2. On11-19-14 an audit of 100 of 100 reside care cards were audited to ensure the reflect of oral care status and any special request n by the residents for morning care; issues identified were addressed at that time.  3. Beginning on 11-20-14 the Staff Development Coordinator in-serviced nursi staff in regards to the revision and the follow of the resident's care cards for Activities of Daily Living, including oral care, and any s requests made by the resident in regards to morning care.  4. Beginning the week of 11-23-14, 3 reside care cards will be audited to ensure they ind the resident's oral status, Activities of Daily Living status, and any special request made the resident for morning care. The audits with conducted by the Minimum Data Set Nurse Registered Nurse Supervisor, and/or Assista Director of Nursing. The audits will be conducted 3 times a week for 4 weeks, 1 tim week for 4 weeks, monthly for 1 month, the quarterly thereafter.  The results of the audits will be reviewed by Quality Assurance Performance Improveme Committee monthly for 3 months. The Dire of Nursing is responsible for monitoring and compliance.  Date of Compliance: 11-28-14	or to  e. ents tion tade  ng wing pecial  ent's licate by ff be ant mes a en	11- 28-14

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: TN7941

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG			E SURVEY IPLETED
		445495	B. WING			10/	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		STREET ADDRESS, 0 490 WEST POPLAR COLLIERVILLE,		1 101	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( EACH CO	ER'S PLAN OF CORRECTIO RRECTIVE ACTION SHOULE ERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 311	Continued From pa	ge 25	F3	11			
	diagnoses of Menin Ataxia, Hypertensio Cardiac Dysrhythm and Hypothyroidism Review of the admi	mission date of 9/8/14 with gioma, Pulmonary Collapse, on, Hyperlipidemia, Hernia, ia, Primary Cardiomyopathy, on.  ssion Minimum Data Set essment reference date of					
	9/15/14 documente Status (BIMS) score #164 was moderate making and require personal hygiene in Review of the 30 da reference date of 10 #164 had a BIMS se #164 was cognitive	d a Brief Interview for Mental e of 9 indicating Resident ely impaired for decision d extensive assistance for cluding brushing her teeth. ay MDS with an assessment 0/4/14 documented Resident core of 15 indicating Resident ly intact for decision making sive assistance for personal					
	"Problem requir oral care Approac Do not rush Allow as needed Assist	an dated 9/22/14 documented, e assist of ADL's including ches Assist as needed extra time to complete ADLs with bathing, grooming needed Provide me oral [as needed]"					
	documented, "Da [checked] Use so	sing summary dated 9/8/14 ily oral care by Staff ft brush or toothettes thwash [checked]"					
	card for Resident # AND COMPLETE A RESIDENT'S STAT Independent Assi	d nursing assistant (CNA) care 164 documented, "CHECK ALL ITEMS THAT DESCRIBE 'US ORAL CARE sted Total Care" The oral checked to indicate the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı		E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		445495	B. WING			10/	30/2014	
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		49	REET ADDRESS, CITY, STATE, ZIP CODE 00 WEST POPLAR AVENUE OLLIERVILLE, TN 38017	107	0012014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 311	resident's status for Observations in Res 10/26/14 at 12:39 P Resident #164's roc call light. Resident # nurse that she want to wash her face an telling the staffing no swabs for her moutin and walked toward in until she was told by resident was still try nurse then returned what else the reside  During an interview 10/26/14 at 12:39 P if she received the her teeth. Resident but I need my toothly they [staff] won't ever Resident #164 was teeth / dentures clea stated, "Twice a wee  During a discussion (DON) on 10/26/14 informed of an incid reported to the surve she was given a she and the diaper was shower was comple does not always rec face and a toothbrui request. The reside	sident #164's room on M, the staffing nurse came in om answering Resident #164's #164 was telling the staffing red a warm soapy wash cloth d before she could finish ruse that she wanted the h, the nurse turned around the door to leave the room y this surveyor that the ing to talk to her. The staffing to the bedside and asked ent needed.  in Resident #164's room on M, Resident #164 was asked nelp necessary for cleaning #164 stated, "No, I can do it orush and a soapy wash cloth, en bring them to me." asked how often are your aned. Resident #164 then		311				
		,		1		į		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	<del></del>		E SURVEY PLETED
		445495	B. WING			10/3	30/2014
	PROVIDER OR SUPPLIER  EALTH & REHAB OF	COLLIERVILLE, LLC		STREET ADDRESS, CITY, S 490 WEST POPLAR AVEI COLLIERVILLE, TN 38	NUE	,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF) TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION TIVE ACTION SHOULD SED TO THE APPROPE FICIENCY)	BE	(X5) COMPLETION DATE
F 311	(provided by the DC investigation for the with a diaper on, the investigation of the wash cloths or a too During an interview 10/28/14 at 9:50 AN want a warm soapy and hands. I ate bresticky and I would lift they would just brocloth. I asked for on have any up here ye of those little good to your mouth I could good." Resident #16 teeth brushed yet the stated, "No."  During an interview dining room on 10/2 was asked if she was CNA #5 stated, "Yes I have had her." CN knows what she is seen that the surveyor could care card was mark CNA #5 was asked do her own bath an her. CNA #5 stated, asked how would you mouth care since no	of concern dated 10/26/14 DN) only documented an concerns of being bathed ere was no documented concerns related to requesting	F				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		E SURVEY MPLETED		
		445495	B. WING	·	<del> </del>	10/	/30/2014		
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		49	STREET ADDRESS, CITY, STATE, ZIP CODE 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 311	her mouth care. Si [mouth care]." CN/ up, I keep her dry. face, bathe her and During an interview on 10/28/14 at 3:20 she had addressed resident related to or her tooth brush stated, "No, I have the other issue, but During an interview on 10/28/14 at 3:55	ed, "The CNA before me gives the [Resident #164] gets it daily A #5 stated, "If she is already If she is not up I wash her diput her clothes on."  If the staff development room D PM, the DON was asked if the concerns from the her not receiving a wash cloth in the mornings. The DON not I was more concerned with t I will."  If the staff development room D PM, the DON was asked if the concerned with the mornings. The DON not I was more concerned with the will."	F	311					
F 314 SS=D	is done. The DON each floor that they have 2 on each flo documentation in the care was being door Review of the facility is gned by the DON "She [Resident #10 toothbrush brough drawer of her beds to brush her teeth. Her drawer and woneeded to get any 483.25(c) TREATM PREVENT/HEAL IT Based on the com	he medical record that ADL ne.  ity's follow up investigation I dated 10/28/14 documented, 64] said she also had a t to her and put into the top side table with a emesis basin She said that she could reach ould call for assistance if personal care items."	F	314	facility on 6-19-14.  2. Beginning on 10/31/14 the Licens the Treatment Nurse, Registered Nurse, Regis	ed Nurses, rse trsing, and			
	who enters the fac	y must ensure that a resident cility without pressure sores pressure sores unless the			the Staff Development Nurse conduct audits on 99 of 99 residents no negativere identified at that time.	cica poay			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		445495	B. WING	i		10	/30/2014	
	PROVIDER OR SUPPLIER EALTH & REHAB OF	COLLIERVILLE, LLC		49	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST POPLAR AVENUE DLLIERVILLE, TN 38017			
(X4) 1D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 314	they were unavoida pressure sores rec services to promote prevent new sores	condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and	F:	314	Beginning the weck of 11-3-14 the Tre Nurse, Registered Nurse Supervisor, A Director of Nursing, and the Staff Dev Nurse conducted an audit of 6 of 6 resi identified with pressure ulcers to ensur treatments were ordered by the physici treatment orders were being administer physician's orders, and pressure ulcer assessments were being conducted were negative issues were identified at that it  3. The Director of Nursing in-serviced	ssistant elopment dents e an, red per the ekly; no ime. the		
	by: Based on medical was determined the treatments, assess treatments without	record review and interview, it e facility failed to provide ments and provided an order for 1 of 2 (Resident idents reviewed of the 2			Treatment/licensed Nurses on 10-31-3-19-14 in regards to removal of dressing evaluation upon admission, conducting documenting skin assessments, document the correct dates on the Treatment Administration Records, and obtaining orders from the physician.  4. Beginning the week of 11-23-14 the	gs and skin ; and entation of treatment		
	documented an ad discharge date of 6 Obstructive Chroni Chronic Airway Ob Chronic Respirator	ed: iew for Resident #128 mission date of 5/27/14 and a 6/19/14 with diagnoses of c Bronchitis with Exacerbation, struction, Emphysema, y Failure, Dysphagia, Speech order and Tobacco Use			Interdisciplinary Team (Director of Nu Assistant Director of Nursing, Registe Supervisor, Minimum Data Set Nurse, Director, and Social Services) will con audits of 3 resident's clinical records where the second of the second o	rsing, red Nurse Activities duct duct ensure and a skin morning nducted 3 eek for 4		
	5/27/14 documented INTEGRITY BREA diagram] dry and in was no skin assess under the dressing Review of Residenthe following:  a. 5/27/14 - "Probled due to paraplegia"	nursing summary dated ed, "SKIN CONDITION SKIN KS: dressing [buttocks on ntact [LEFT BLANK]" There sment documented for the skin of the buttock area.  t #128's care plan documented em at risk for skin breakdown. Approaches Provide surfaces on bed and chair"			Interdisciplinary Team (Director of Ni Assistant Director of Nursing, Registe Supervisor, Minimum Data Set Nurse Director, and Social Services) will con audit of treatments of residents having ulcers to ensure treatments were order physician, treatment orders are being administered per the physicians orders pressure ulcer assessments are being c weekly. The audits will be conducted week for 4 weeks, 1 times a week for monthly for 1 month, then quarterly the	red Nurse Activities Iduct an pressure ed by the and		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	•	445495	B, WING_		10.	/30/2014	
	PROVIDER OR SUPPLIER EALTH & REHAB OF	COLLIERVILLE, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 314	Approaches weel healing need a fur bath/shower"  Review of a "Daily / and Hydration Report document any condition of the nurses notes of a coccyx or sacral v 5/27/14, 5/28/14, 5/6/12/14.  Review of wound and documented the folia. Identified on 5/27 pressure ulcer (not b. 5/28/14 - Resident coccyx.  c. 6/8/14 - Resident ulcer to his sacrum d. 6/12/14 - Resident wound to his sacrum Review of skin inspection of the skin Not d. "6/3/14 Skin Not d. "6/13/14 Skin Not d. "6/17/14 Skin Not f. "6/18/14 Skin Skin f. "6/18/14 Skin f.	sure ulcer? Sacrum dy evaluation of wound Il skin evaluation weekly with  Weekly / Monthly Body Audit ort" dated May 2014 did not eerns of the skin.  id not have documentation of wound assessment for 29/14 or from 6/8/14 to  and skin status reports lowing: 7/14 Resident #128 had a staged) to his sacrum. ant #128 had a DTI to his  a #128 had a stage 2 pressure ant #128 had an unstageable an.  ection reports documented  at Intact" Intact	F 31	Beginning the week of 11-23-14, th Nurses, Treatment Nurses, and/ or to Nurse Supervisors, will conduct we assessments on the residents. The awill be reconciled against the residents the Assistant Director of Nursing and Registered Nurse Supervisor week!  Beginning the week of 11-23-14, the Nursing Assistants will conduct boothe residents three times weekly. The assessments will be reconciled again resident census by the Assistant Din Nursing, Treatment Nurse, and/or Nurse Supervisor 3 times weekly.  The results of the audits will be reveredulity Assurance Performance Im Committee monthly for 3 months. of Nursing is responsible for monit compliance.  Date of Compliance: 11-28-14	ne Registered ekly skin sseessments ent census by end/or y.  ne Certified dy audits on ne nst the rector of Registered iewed by the provement The Director	11- 28-14	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		445495	B. WING			10/	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		49	REET ADDRESS, CITY, STATE, ZIP CODE 00 WEST POPLAR AVENUE OLLIERVILLE, TN 38017	1 10	00/2014
(X4) ID PREFIX TAG	(ÉACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X6) COMPLETION DATE
F 314	a. 5/28/14 did not diskin on Resident #1 b. 6/5/14 - Resident on his buttocks with c. 6/11/14 - an area #128's buttocks with Review of Resident evaluation forms do a. 5/29/14 - an unst tissue loss- depth u (localized area of difilled blister) of the c 5/29/14 but had bed days. b. 6/12/14 - a stage subcutaneous fat mof the sacrum with reare. c. 6/19/14 - an unst with recommendation. The facility was una of any braden scale. Review of a wound documented on 6/8. Resident #128 had ulcer of the sacrum. Review of a Patient documented the folia. Week 1 dated 5/2 c PU [pressure ulb. Week 2 dated 6/5 skin concerns. c. Week 3 dated 6/5 cleanse sacral oper	a circle around the area. of concern on Resident n a circle around the area. of concern on Resident n a circle around the area.  #128 wound care specialist cumented the following: ageable (full thickness skin or nknown) deep tissue injury scolored intact skin or blood coccyx that resolved on en present greater than 2  3 (full thickness skin loss ay be visible) pressure wound ecommendations for wound ageable wound of the sacrum ons for wound care.  ble to provide documentation assessments completed. healing progress report /14, 6/12/14 and 6/19/14 that an unstageable pressure  at High Risk (PAR) notes lowing: 28/14 - "Resident admitted	F	314			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	0	(3) DATE SURVEY COMPLETED
		445495	B. WING			10/30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		STREET ADDRESS, CITY, STATE, ZIP 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017	CODE	10.00,2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	• • • • • • • • • • • • • • • • • • • •	N SHOULD BE E APPROPRIA	
F 314	wound treatment to wound cleanser, prevery 3 days was of 5/8/14 through 5/11 admitted until 5/27. Review of the MAF Nursing (DON) stated (DON) state	2014 Medication cord (MAR) documented the orcleanse sacral wound with at dry and apply hydrocolloid documented as being done on 1/14. Resident #128 was not //14.  Resident #128 was not //14.  Redated 5/2014 (the Director of ted this was actually a MAR for in inaccurate date) canse sacral wound c [with] at dry, apply hydrocolloid q further order" There were no MAR for 5/27/14, 5/28/14 or Redated 6/2014 documented, to sacrum c wound cleanser. alcium Alginate QOD [every 1/27 days. 6/12/14" These ocumented as being done yet, cian order documented for this in the staff development room 5 PM, Treatment Nurse #1 ge. The only time I measure the esident comes in and I all [named wound care doctor] that to put down for atment Nurse #1 stated, "The and the doctor does the did will write down the doctors's	F3			
	computer for the fa	d then place them in the acility's documents. The wound the documentation that she ormation the facility has for				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY IPLETED
		445495	B. WING		····	10/	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		490	EET ADDRESS, CITY, STATE, ZIP CODE WEST POPLAR AVENUE LLIERVILLE, TN 38017	1 10	00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	assessments is the doctor once it is doc not need the inform copy. The certified in nurses do skin assenurses also use the completes the form nurse, and after 3 n Treatment Nurse #* #128's pressure uld stated, "He had a D [5/27/14]." Treatment nurses notes had at Treatment Nurse #* see any."  During an interview on 10/28/14 at 5:00 was asked for a pol wound care. The Nurse defined this is our interdiscipatient's at risk, disc RD [Registered Die like a mattress. This have a written protoprocess." The Nurse do the nurses know policy. The Nurse C Braden Scale."	dictation from the wound care cumented. The facility does ation and we do not keep a nursing assistants (CNAs) and essments with the baths. The skin audit sheet, the nurse, and gives to the treatment nonths, they are discarded." I was asked about Resident er. Treatment Nurse #1 TI when he came in not Nurse #1 was asked if the ny wound documentation. I stated, "No ma'am. I don't in the staff development room PM, the Nurse Consultant icy for skin assessments and urse Consultant stated, "If a high risk they go through PAR olinary team. We discuss cuss patient's needs with the tician] and if needs equipment is is all we've got. We don't in the consultant was asked how what to do if there is no consultant stated, "We have a lin the staff development room PM, the Nurse Consultant lent is admitted with a	F 3	14			
	do. The Nurse Cons should have taken i at the skin." There v	ocks, what should the nurses sultant stated, "They [nurses] t [the dressing] off and looked was no documentation of a ovided when the resident was					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		X3) DATE SURVEY COMPLETED	
		445495	B. WING_			10/30/2014	
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		STREET ADDRESS, CITY, STATE, ZIP C 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD E		7
F 314	admitted.  During an interview on 10/29/14 at 10:3 was asked where the unstageable DTI of dictated form. The vertice of the wound care do receives her inform building and the fact wound care doctor or they see someth them what to put do it." The wound care documentation on 6 documented a stage did she remember a doctor stated, "Calle [Treatment Nurse], looked, rounds wound that is what we During an interview on 10/30/14 at 12:3 (DON) was asked it Daily / Weekly / Moreport was consider assessment. The Dwas asked what the DON stated, "An an stated, "When the vertice of would assess the vertice of would be doclooks like." The DO assessment of would assess as well as a second a	in the staff development room 5 AM, the wound care doctor he information for the the coccyx came from on the wound care doctor stated, "I for it and it not being there." ctor was asked where she ation from if she is not in the stated, "If they are suspicious ing they will call me and I tell own. I will go back and look at doctor was asked about 6/12/14 where she had a 3 pressure wound, and what about this. The wound care and me on the weekend, it was told me how the wound ld be later. The treatment a, it is described on the phone go by."  In the staff development room 5 PM, the Director of Nursing if the undated and unsigned nthly Body Audit and Hydration and a body audit and skin in inconstated, "Yes." The DON circled area might be. The ea of concern." The DON wound nurse comes in she wound." The DON stated, cumented what the wound N was asked about the nds. The DON stated, "The	F 3 <sup>-</sup>	14			
		re did have was difficult, the it or had difficulty learning it.				i	

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PRINTED: 11/17/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

		445495	B. WING			10/3	30/2014
NAME OF F	ROVIDER OR SUPPLIER			ŞT	REET ADDRESS, CITY, STATE, ZIP CODE		
	•				0 WEST POPLAR AVENUE		
DOVE HE	ALTH & REHAB OF C	COLLIERVILLE, LLC		C	OLLIERVILLE, TN 38017		
	CUMMADV CTA	TEMENT OF DEFICIENCIES	ID	1	PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	PREFI	x ¦	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
TAG		C IDENTIFYING INFORMATION)	TAG	l	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
		<u> </u>		<u> </u>	DEFICIENCY)		
Ì	<del></del>						
F 314	Continued From pag	ge 35	F3	14	1		
}	The information [na	med Treatment Nurse #2]			F 323		
	would put in did not	match the information that			1. Resident # 64 was re-evaluated on 11-11-	14	1
	inamed wound care	doctor] had on her notes, the		ļ	by the Interdisciplinary Team (Director of	14	
	stages never match				Nursing, Assistant Director of Nursing.		
F 323	483.25(h) FREE OF	ACCIDENT	F 3	23	Registered Nurse Supervisor, Minimum Dat Nurse, Activities Director, and Social Service	a Set	.
SS=E	HAZARDS/SUPER	/ISION/DEVICES			in regards to fall risk and the use of the bed s	nd	
					chair alarms. Resident # 64's attending phys:	ician	
İ		sure that the resident			was notified on 11-11-14 by the Director of Nursing and new orders were received to		
		s as free of accident hazards			discontinue the bed alarm. After Interdiscipli	narv	<b> </b>
ļ		each resident receives			Team review on 10-31-14, resident #64's che	ir .	
		on and assistance devices to		ŀ	alarm was removed and resident # 64's care was revised at that time,	olan	
	prevent accidents.			1	This revised at that time,		
				1	Resident # 169's Medication Administration		
				1	Record was revised on 11-1-14 by staffing		
				ì	development coordinator to reflect the need for checking placement and functioning of the be	or or	
	This RECUREMEN	IT is not met as evidenced		1	alarm and chair alarm.	·	
	by:	ar is not met as evidenced		i	The razor was removed from room 210 and		
	Based on medical i	record review, review of an			discarded in the biohazard/sharps container or	,	
	incident report, obse	ervation and interview, it was			10-31-14 by Director of Nursing.	•	
	determined the facil				2. On 10.21 14.7 -67	_	
		n place and followed to			2. On 10-31-14 7 of 7 residents were observe by the Director of Nursing and Assistant	d	
	prevent potential fal	ls for 2 of 3 (Residents #64			Director of Nursing to ensure residents with		
	and 169) sampled r	esidents with falls and the		1	interventions for bed or chair alarms were inta	ct.	
	facility failed to ensu	re the environment was safe			In addition, the care plans of residents with interventions for bed or chair alarms were		
	as evidenced by un	secured razors in 1 of 51			audited at this time; no further issues were		
•	(room 210) rooms.				identified,		
					On 11-24-14 the Director of Nursing conducte	rđ	
	The findings include	<del>2</del> a:			an audit of 20 incident/ accident reports from t	he	
	4 Daview of the fo	cilibre falle policy			past 90 days to ensure fall interventions were		
	1. Review of the fa	the policy of this facility to		Į	,		
	occumented,It is	r the potential for falls and		i	1		
	identify factors that	might contribute to falls. The		1			
	facility will address:	those factors identified in					
	order to reduce the	risk for falls					<u>:</u> 
	PROCEDURE 3	If the resident has fallen in the					
	past month, the res	ident will be considered at					
	Page months are 100						

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_

Facility ID: TN7941

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		445495	B. WING	·	<u> </u>	10	/30/2014	
	PROVIDER OR SUPPLIES EALTH & REHAB OF	COLLIERVILLE, LLC	<u> </u>	490	REET ADDRESS, CITY, STATE, ZIP CODE D WEST POPLAR AVENUE DLLIERVILLE, TN 38017			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	high risk regardles care plan should to address the most.  2. Medical record documented an adiagnoses of Malin Depressive Disord Late Effects of Cestate and Lack of October, 2014 recommented, "Bed alarm to all [start date 1/4/14].  Review of an incide documented, "In position of resident get back into bed'. INCIDENT what Resident attempts wheelchair without during or immediating or immediating and to prevent fut Reeducated on case documented, "Figet back in bed in educated reside issues. This nurse issues and transfer Review of a care documented, "Figet pack in sed in educated Coside rails x [times	ss of their risk score 4. The be updated after a fall to recent cause of the fall"  I review for Resident #64 dmission date of 11/23/10 with gnant Neoplasm of the Colon, der, History of Fall, Joint Pain, prebrovascular Accident, Anxiety Coordination. Review of the certification orders documented, ert staff of unassisted transfers"  Ident report dated 10/21/14 decident Fall What was not? sitting upright on the floor say happened? 'I was trying toINVESTIGATION OF to CAUSED this incident ed to transfer self to bed from that assistance What was done at left and chair alarm"  See' notes dated 10/21/14 desident states "I was trying to to bed." Resident has been ent several times on safety ere-educated resident on safety after this incident on safety are-educated resident on safety	F	323	added to the resident's care plan; no furtissues were identified at that time.  On 11-1-14, 7 of 7 residents with intervence for bed and chair alarms were audited to the resident's Medication Administration Records indicated to check placement a functioning each shift by assistant direct supervisor; issues identified were addrest that time.  On 10-31-14, 51 rooms of 51 rooms were audited by the Registered Nurse Superv Assistant Director of Nursing, and Staff Development Coordinator to ensure raze not left unattended; no further issues were identified.  3. Beginning on 11-20-14 the Staff Development of the revision and the following plans and care cards for placement of the bed alarms.  Beginning on 11-20-14 the Staff Development of the staff Development of the staff Development of the staff Development of falls.  Beginning on 11-20-14 the Staff Development of the resident's Medication Administration Record to ensure place functioning are checked each shift.  Beginning on 11-20-14 the Staff Development of the securing and discarding the securing and discard	entions o ensure on nd tor & RN ssed at  re risors, f cors were cre velopment ff in g of care hair and lopment urses in tion of the  lopment aff in of razors. dits of 3 dd/or chair alarm is l be Nurse, Assistant oc s, 1 times a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	445495	B. WING	•			10/30/2014	
NAME OF PROVIDER OR SUPPLIER  DOVE HEALTH & REHAB OF C		STREET ADDRESS, CITY, STATE, ZIP CO 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017		WEST POPLAR AVENUE LLIERVILLE, TN 38017	DE		
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
Observations in Res at 8:15 AM, revealed back, a clip alarm we clip part of the alarm connected to the reshanging under the beconnected.  Observations in Reseat 2:50 PM, revealed wheelchair at bedsich hanging on the bed to the resident.  Observations in the 10/28/14 at 3:45 PM sitting in her wheelchair or climater wheel	ate R/T [related to] asking for"  sident #64's room on 10/28/14 d Resident #64 in bed on her as on the side rail with the hanging down and not sident. There was an alarm sed and that alarm was not sident #64's room on 10/28/14 d Resident #64 sitting up in a de. There were 2 alarms rail and neither was attached therapy department on 1, revealed Resident #64 hair. There was no alarm on ipped to the resident.  following the care plan rms and there were no new mented on the care plan after	F3	23	Beginning the week of 11-23-14 audit resident care plans who have sustained be audited by the Minimum Data Set Registered Nurse Supervisor, and/ or Director of Nursing to ensure care plate been revised with fall reduction interthe audits will be conducted 3 times 4 weeks, 1 times a week for 4 weeks, for I month, then quarterly thereafter Beginning the week of 11-23-14, 3 rewith interventions for bed and chair a be audited to ensure the resident's Me Administration Records indicate to of placement and functioning each shift Assistant director of nursing. The audited will conducted by the Minimum Data Set Registered Nurse Supervisor, and/or Director of Nursing. The audits will conducted 3 times a week for 4 weeks week for 4 weeks, monthly for 1 mon quarterly thereafter.  Beginning the week of 11-23-14 the I Nurse Supervisor, Assistant Director Staff Development Coordinator, and Supply Nurse will conduct environment observations to ensure razors are not unattended. The environmental obserbe conducted 3 times a week for 4 we times a week for 4 weeks, monthly for then quarterly thereafter.  The results of the audits will be review Quality Assurance Performance Improcommittee monthly for 3 months. The of Nursing is responsible for monitoric compliance.  Date of Compliance: 11-28-14	Assistant  ans have ventions. a week for monthly  esidents alarms will edication heck by dits will be Nurse, Assistant be s, I times a ath, then  Registered of Nursing, Central ental left vations will tecks, 1 or 1 month, weed by the overment the Director	11- 28-14	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l''	LTIPLE CONSTRUCTION DING	(X	(X3) DATE SURVEY COMPLETED	
		445495	B. WING	I		10/30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		STREET ADDRESS, CITY, STATE, 3490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIA	
F 323	alarm was initiated. "I'm not seeing whe usually write an ord has a history of falls MDS coordinator w wheelchair alarm be the MDS coordinator order written it shou orders and the incic [Director of Nursing and reviews the interm interventions is by for the care plan wheelchair alarm uncheck and let you k During an interview on 10/30/14 at 12:1 stated, "I spoke with chair alarm don't ne nursing intervention was here when she that the chair alarm is in the care plan. The I the intervention should be intervented in the chair alarm is on the chair alarm is on the chair alarm is don't need to the chair alarm is need t	The MDS coordinator stated, are it was ordered. They er for it. She [Resident #64] is. I can look in overflow." The as asked, should the expectated included on the care plantor stated, "If there was an all be on there. We get the dent reports after the DON I looks at the incident report erventions. The DON puts long in place and that is what we go it. I can't find the order for the inless it is in overflow I will now."  In the staff development room to PM, the MDS coordinator in the DON and she said the ead an order because it is a in, I spoke with the nurse that had the fall and she told me was put on when she had the MDS coordinator was asked use, should it be included on MDS coordinator confirmed and be on the care plan. This ed when the chair alarm was coordinator stated it was fall. This surveyor asked why occumented in the 5/1/14 MDS coordinator stated, "Do to check in overflow." No	F3	323		
	documented an adr diagnoses of Gastro	mission date of 10/09/14 with pintestinal Hemorrhage, Heart ellitus, Hyperlipidemia and				!

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (C1) PROVIDER/SURPLIER/CLIA

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1 ' '	TIPLE CONSTRUCTION ING			E SURVEY IPLETED
		445495	B. WING			10/	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		STREET ADDRESS, CITY, STATE, ZIP ( 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017	ODE	101	30/2014
(X4) ID PREFIX TAG	· (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		SHOULD	BE	(X5) COMPLETION DATE
F 323	Alzheimer's Disease Review of the care documented, "Ris falls bed/chair ala placement and func Review of the Medic (MARS) for Octobe Alarm, Chair Alarm bilateral Bed 7A-7 documentation asse alarm was functioni During an interview on 10/28/14 at 5:30 how does she chec bed and chair alarm my hand on the pac chair and raise my I Nurse #2 was aske it was checked. Nur every shift."  During an interview on 10/28/14 at 5:45 view the MARS who bed and chair alarm Nurse #3 stated, "H where it is suppose that there was no de and functioning was 3. Observations in AM, revealed an un table.  During an interview	plan dated 10/19/14 k for falls related to recent rm as ordered, check stion Q [every] shift"  cation Administration Record r 2014 documented, "Bed Landing strips Applied to P 7P-7A" There was no essing that the bed and chair ng or in place.  at the 300 hall nurses' station PM, Nurse #2 was asked k placement and function of us. Nurse #2 stated, "I just put I where it is on the bed or the hand up and it should alarm. d where is it documented that the #2 stated, "On the MARS  at the 300 hall nurses' station PM, Nurses #3 was asked to are it was documented that the in was checked every shift. ere [pointing at the MARS] is d to be." Nurse #3 confirmed ocumentation the placement		23			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445495	B. WING			10/:	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		49	TREET ADDRESS, CITY, STATE, ZIP CODE 90 WEST POPLAR AVENUE OLLIERVILLE, TN 38017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	RTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	(DON) was asked it unsecured in reside "No, should not be During an interview on 10/29/14 at 5:05 have a policy for unbut it is our protoco use in biohazard." 483.35(i) FOOD PR STORE/PREPARE/The facility must - (1) Procure food froconsidered satisfac authorities; and	f razors should be left ent's rooms. The DON stated, left unattended.  In the staff development room of PM, the DON stated, "Do not nattended / unsecured razors, I to discard the razors after ROCURE, //SERVE - SANITARY  In sources approved or story by Federal, State or local distribute and serve food		323	F 371  1. CNA # 2 and CNA # 3 were in-serviced on 11-4-14 by the Staff Development Nurse in regards to hand hygiene, including emphasis of the washing of hands after each direct resident contact, after contact with inanimate objects/at or after the removal of gloves.  Residents # 97 and # 55 were assessed by Director of Nursing on 10-31-14; no negative issues were identified.  The chocolate milk was discarded on 10-26-14 by the Assistant Director of Nursing.  2. An observational audit of the meal service we conducted on 11-3-14 by Staffing Development Coordinator to ensure hand hygiene was  conducted per requirements; no negative issue were identified at that time.  On 10-26-14 and 11-12-14, an audit of the expiration dates of milk was conducted by the Dietary Manager; no negative issues were identified.	vas nt	
	by: Based on policy reinterview, it was defensure practices to of infection were members (Certified and 3) during dining milk was not served of the 20 residents.  The findings include 1. Review of the fa	view, observation and termined the facility failed to prevent the potential spread aintained by 2 of 24 staff I Nursing Assistant (CNA) #2 g and failed to ensure expired d, which could have affected 2 eating in the fine dining room.			3. Beginning on 11-23-14 the Staff Developm Coordinator and the Assistant Director of Nursing in-serviced and performed hand hygiskills checks with the nursing staff.  On 11-12-14 the Administrator in-serviced the Dietary Manager in regards to checking the expiration dates of milk.  On 11-12-14 the Administrator in-serviced the dietary staff in regards to checking the expiration dates of milk.	ene e	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445495	B. WING			10/	30/2014
DOVE H	SUMMARY STA	COLLIERVILLE, LLC	ID	49 C(	REET ADDRESS, CITY, STATE, ZIP CODE 10 WEST POPLAR AVENUE OLLIERVILLE, TN 38017  PROVIDER'S PLAN OF CORRECTION SHOULD	ON	(X5)
F 371	Continued From paragraph potentially infected that could be trans the following infect GUIDELINES 5. alcohol-based hand hygiene: A. Before residents C. After skin E. After contact a. Observations in 10/28/14 at 8:00 Alassisting Resident CNA #2 got up and then returned and #97 without perform During an interview on 10/29/14 at 7:35 Nursing (ADON) with the desident #55 up in and the bed, remore performing hand higher tray.  During an interview on 10/26/14 at 12:30 to the overbed tab Resident #55 up in and the bed, remore performing hand higher tray.  During an interview on 10/29/14 at 4:33 (DON) was asked touching residents	or colonized with organisms mitted in the facility and apply on control practices If hands are not visibly soiled, drubs are preferred for hand having direct contact with recontact with recontact with resident's intact act with inanimate objects" Resident #97's room on M, revealed CNA #2 was #97 with the breakfast meal. repositioned Resident #18, continued to assist Resident ning hand hygiene.  In the staff development room as asked what she expects sisting to feed a resident and er resident. The ADON stated, and I prefer them to wash their Resident #55's room on PM, CNA #3 placed a meal tray le, applied gloves, assisted the bed, touching the resident yed her gloves, without ygiene and continued to set up what should staff do after in between glove use, and The DON stated, "Should	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)  4. Beginning on the week of 11-23-14 an observational audit of the meal service will conducted by the Registered Nurse Superv Assistant Director of Nursing, Director of Nursing, Staff Development Nurse, and/ of Central Supply Nurse to ensure hand hyging performed per requirements. The observat audits will be conducted 3 times a week for weeks, 1 times a week for 4 weeks, month 1 month, then quarterly thereafter.  Beginning on the week of 11-23-14 an audit expiration dates of milk will be conducted Dietary Manager. The audits will be conducted Dietary Manager. The audits will be conducted Dietary Manager. The month, then quarterly thereafter.  The results of the audits will be reviewed Quality Assurance Performance Improver Committee monthly for 3 months. The Administrator is responsible for monitoric compliance.  Date of Compliance: 11-28-14	PRIATE  Il be visor,  or the ene is ional or 4 lily for dit of 1 by the ucted 3 for 4 ly  by the ment	11- 28-14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		445495	B. WING			10	/30/2014	
		COLLIERVILLE, LLC		490 WE	ADDRESS, CITY, STATE, ZIP CO ST POPLAR AVENUE ERVILLE, TN 38017	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	·   ·	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 425 SS=D	10/26/14 at 12:30 fichocolate milk with in a pan of ice to be lunch meal. There room for lunch.  During an interview 10/26/14 at 1:12 Pl Nursing (ADON) we chocolate milk that The ADON stated, ADON then proceed and put them into the 483.60(a),(b) PHAI ACCURATE PROCEED The facility must prodrugs and biological them under an agression of a lice. A facility must prove (including procedulacquiring, receiving administering of all the needs of each.)  The facility must element of the facility must prove (including procedulacquiring, receiving administering of all the needs of each.	the fine dining room on PM, revealed 2 cartons of an expiration date of 10/24/14 error served to residents with their were 20 residents in the dining of in the fine dining room on the Assistant Director of as asked would you expect is being served to be expired. "No, it shouldn't be." The ended to remove it off the tray the trash. RMACEUTICAL SVC - CEDURES, RPH to vide routine and emergency the sto its residents, or obtain the to administer drugs if State and the services of cist who provides consultation the provision of pharmacy.	F 4	F 42  1. F faci  2. E were  Asserted As	Resident # 173 was discharged from lity on 11-3-14.  Beginning on 11-3-14, 6 of 6 medicate audited for medication availabilismparison with the physician's ordedications by the Director of Nursing sistant Director of Nursing; no negare identified.  Beginning on 11-20-14 the license aff was in-serviced by the Staff Deporting on the week of 11-23-12 ain medications.  Beginning on the week of 11-23-12 ain medications faxed to the pharmar refill will be conducted and reconclivery manifest from the pharmac icensed Nurse, Registered Nurse Sasistant Director of Nursing and/observelopment Coordinator. The audionducted 3 times a week for 4 week for 4 weeks, monthly for 1 mounterly thereafter.  The results of the audits will be reviguality Assurance Performance Implementation of Nursing is responsible for monite ompliance.  Date of Compliance: 11-28-14	cation carts ity in  ers for pain ing and gative issues  ed nursing evelopment lelivery of  14 an audit of nacy for fill nacided to the y by the hupervisor, or Staff its will be eks, 1 times a onth, then  iewed by the provement The Director	11- 28-14	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED		
		445495	B. WING			10/	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC	<b>.</b>	490	REET ADDRESS, CITY, STATE, ZIP CODE D WEST POPLAR AVENUE DLLIERVILLE, TN 38017	, 10,	00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	Continued From pa	•	F 4	25			
	by: Based on medical was determined the provider failed to er medications was de (Resident #173) sa	record review and interview, it efacility's pharmaceutical asure prescribed pain elivered timely 1 of 23 ampled residents reviewed for the 44 residents included in the					
	The findings include	ed:	  -  -				
	documented an addiagnoses of Congo Ulcer of the Lower	ew for Resident #173 nission date of 10/16/14 with estive Heart Failure, Venous Left Leg and and Left Inner nia and Hypertension.					
	#173's pain medica documented, "Hydr milligrams (mg) hyd acetaminophen] i [c h [hours] prn [as ne The facsimile trans	an's prescription for Resident tion dated 10/23/14 occodone 10/325 [10 drocodone and 325 mg one] po [by mouth] q [every] 4 deded] pain x [times]14 days] mission verification report was 1:30 AM as received by the vider.					
	PM documented Repain. Resident #173	s note dated 10/26/14 at 7:30 esident #173 complained of 3's personal prescribed pain available on the 3rd floor					
	10/30/14 at 11:00 A provider's Director	in the dining room on M, the pharmaceutical of Clinical Operations, was at #173's pain medication had					

•	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		445495	B. WING _		10/30/2014	
	PROVIDER OR SUPPLIER  EALTH & REHAB OF OR SUMMARY STA	COLLIERVILLE, LLC	STREET ADDRESS, CITY, STATE, ZIP COI 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017  ID PROVIDER'S PLAN OF CORR			
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
F 425	not been delivered pharmaceutical pro Operations stated, I realize we failed, I control, [the facility! hydrocodone tablet	to the facility. The vider's Director of Clinical "It was an order entry mistake, and measures in place for pain s Emergency Kit had savailable]."	F 42	F 431  1. On 11-11-14 Nurses #2 and # 4 were inserviced by the Staff Development Coordinatin regards to leaving medications unattended		
F 431 SS=D	The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled.  Drugs and biological labeled in accordant professional princip appropriate access instructions, and the applicable.  In accordance with facility must store a locked compartmer controls, and permit have access to the The facility must propermanently affixed controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except when	apploy or obtain the services of sist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically als used in the facility must be be with currently accepted les, and include the ory and cautionary expiration date when state and Federal laws, the II drugs and biologicals in ints under proper temperature to only authorized personnel to	F 43	2. On 11-14-14 medication pass audit by observation was conducted by Assistant Dire of Nursing to ensure medications were not led unattended; no negative issues were identified.  3. Beginning on 11-20-14 the licensed nurse were in-serviced by Consultant Pharmacist is regards to not leaving medications unattended and unsecured.  Beginning 11-19-14 the licensed nurses were serviced by Staff Development Coordinator regarding not leaving medications unattended.  4. Beginning on the week of 11-23-14 observational audits during medication administration will be conducted by the Registered Nurse Supervisor, Assistant Dire of Nursing and/or Staff Development Coordinator to ensure medications are not led unattended or unsecured. The audits will be conducted 3 times a week for 4 weeks, 1 times week for 4 weeks, monthly for 1 month, then quarterly thereafter.  The results of the audits will be reviewed by Quality Assurance Performance Improvemer Committee monthly for 3 months. The Director Nursing is responsible for monitoring and compliance.  Date of Compliance: 11-28-14	eff ed.  s n d ein- d.  ctor ft es a	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		445495	B. WING	_		10/	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		4	STREET ADDRESS, CITY, STATE, ZIP CODE 190 WEST POPLAR AVENUE COLLIERVILLE, TN 38017	7 10	00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From pa quantity stored is m be readily detected.	inimal and a missing dose can	F 4	<b>131</b>			
	by: Based on observat determined the faci (Nurses #2 and 4) r	NT is not met as evidenced ion and interview, it was lity failed to ensure 2 of 5 medication nurses did not unattended and out of their					
	The findings include	ed:					
	10/28/14 at 9:30 AM prepared medicatio walked to the hall to in pulling this resider resident up in the bothe bathroom. Nursunattended and out	Resident #120's room on II, revealed Nurse #2 placed ns on the overbed table, o get a staff member to assist ent up in the bed, assisted this ed, and washed her hands in e #2 left the medications of sight as she left the room er and while she was in the her hands.					
	10/28/14 at 10:19 A medications on the bathroom to wash in	Resident #63's room on M, revealed Nurse #4 placed overbed table, went into the ner hands, and left the overbed table unattended and					
	room on 10/29/14 a Nursing (DON) was being left unattende	ew in the staff development it 4:35 PM, the Director of asked about medications ed. The DON stated, "They d not be left unattended."					

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		445495	B. WING		' 	10/	30/2014
DOVE H	PROVIDER OR SUPPLIER			49	TREET ADDRESS, CITY, STATE, ZIP CODE 90 WEST POPLAR AVENUE OLLIERVILLE, TN 38017		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 F 441 SS=E	483.65 INFECTION SPREAD, LINENS  The facility must es Infection Control Prosafe, sanitary and control of disease and infection Control The facility must est Program under which (1) Investigates, corring the facility;  (2) Decides what proshould be applied to (3) Maintains a reconductions related to infection when the Infection determines that a represent the spread isolate the resident.  (2) The facility must communicable disease from direct contact will trace (3) The facility must hands after each direct contact will trace (3) The facility must hands after each direct contact will trace (3) The facility must hands after each direct contact will trace (3) The facility must hands after each direct contact will trace (3) The facility must hands after each direct contact will trace (4) The facility must hands after each direct contact will trace (5) The facility must hands after each direct contact will trace (6) The facility must hand washing is independent of the facility must hand washing is independent of the facility must hand washing is independent.	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ation.  Program tablish an Infection Control and it - introls, and prevents infections occurred, such as isolation, an individual resident; and and of incidents and corrective fections.  and of Infection on Control Program asident needs isolation to of infection, the facility must prohibit employees with a lase or infected skin lesions with residents or their food, if ansmit the disease. The rectire is accepted.	F4 F4		1. CNA # 2 and CNA # 3 were in-serviced on 11-4-14 by the Staff Development Nurse in regards to hand hygiene, including emphasis the washing of hands after each direct resident contact, after contact with inanimate objects and/or after the removal of gloves.  Residents # 97 and # 55 were assessed by Director of Nursing on 10-31-14; no negative issues were identified.  Nurse # 4 was in-serviced on 11-25-14 by the Director of Nursing in regards to hand hygien during the administration of medications, with emphasis placed on the administration of eye ointments.  Nurse # 5 was in-serviced on 11-25-14 by the Director of Nursing in regards to the utilization of gloves during insulin administration.  Nurse # 6 was in-serviced on 11-26-14 by the Director of Nursing in regards to discarding dropped pills and performing hand hygiene during medication administration.  Resident # 63 was assessed on 10-31-14 by Director of Nursing; no negative issues were identified.  Resident # 83 was assessed on 10-31-14 by Director of Nursing; no negative issues were identified.  Resident # 51 was assessed on 10-31-14 by Director of Nursing; no negative issues were identified.	on it see h	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA CO	(X3) DATE SURVEY COMPLETED	
		445495	B. WING	;		10	/30/2014	
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		4	TREET ADDRESS, CITY, STATE, ZIP COD 90 WEST POPLAR AVENUE COLLIERVILLE, TN 38017	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 441	This REQUIREME by: Based on policy reinterview, it was deensure practices to of infection were members (Certified and 3) during dininand 6) nurses during the findings included.  The findings included the finding included the finding included the finding included the finding direct with orgative are preferred thaving direct contact with resided contact with inaninary removing gloves  Observations in 10/28/14 at 8:00 A assisting Resident CNA #2 got up and contact with and contact with resided contact with resided contact with inaninary removing gloves	NT is not met as evidenced eview, observation and etermined the facility failed to prevent the potential spread raintained by 2 of 24 staff d Nursing Assistant (CNA) #2 g and by 3 of 5 (Nurses #4, 5 and medication administration.  Ided:  acility's "Standard Precaution: a Equipment" policy  OVES 6. Wash hands emoving gloves to avoid ganisms to other resident or anisms that could be acility and apply the following actices GUIDELINES If olly soiled, alcohol-based hand for hand hygiene: A. Before act with residents C. After int's intact skin E. After nate objects F. After	F	441	2. An observational audit of the meal's conducted on 11-3-14 by Staffing Dew Coordinator to ensure hand hygiene wa conducted per requirements; no negative were identified at that time.  On 11-14-14 medication pass audit by observation was conducted by Staff Development Coordinator to ensure han hygiene, the wearing of gloves during administration, and discarding of dropp was performed per requirements; no ne issues were identified at that time.  3. Beginning on 11-23-14 the Staff Devel Coordinator and the Assistant Director Nursing in-serviced and performed han skills checks with the nursing staff.  Beginning on 11-20-14 the Staff Devel Coordinator and the Assistant Director Nursing in-serviced the licensed nurses regards to hand hygiene during medical administration, the wearing of gloves d insulin administration, and the discarding dropped pills.  4. Beginning on the week of 11-23-14 a observational audit of the meal service conducted by the Registered Nurse Sup Assistant Director of Nursing, Director Nursing, Staff Development Nurse, and Central Supply Nurse to ensure hand hyperformed per requirements. The observational medication pass audit will be conducted 3 times a week weeks, 1 times a week for 4 weeks, mon 1 month, then quarterly thereafter.  Beginning on the week of 11-23-14 an observational medication pass audit will conducted by the Staff Development Coordinator, Assistant Director of Nurse Supervisor hand hygiene, the wearing of gloves duinsulin administration, and discarding opills is performed per requirements. The observational audits will be conducted week for 4 weeks, 1 times a week for 4 weeks for 4 weeks, 1 times a week for 4 weeks for 4 weeks, 1 times a week for 4 weeks for 4 weeks, 1 times a week for 4 monthly for 1 month, then quarterly the monthly for	elopment as we issues  and insulin ped pills egative  velopment of ad hygiene  dopment of s in tion luring ing of  an will be pervisor, of li/or the tygiene is vational k for 4 mithly for  and the sing, to ensure uring of dropped egative		

	T OF DEFICIENCIES OF CORRECTION	I (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		E CONSTRUCTION		E SURVEY PLETED
		445495	B. WING	·		10/	30/2014
	PROVIDER OR SUPPLIER  EALTH & REHAB OF (	COLLIERVILLE, LLC	<del>!</del>	4	TREET ADDRESS, CITY, STATE, ZIP CODE 90 WEST POPLAR AVENUE COLLIERVILLE, TN 38017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	tD PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	#97 without perform During an interview on 10/29/14 at 7:35 Nursing (ADON) was staff to do when ass repositioning anothe "Clean their hands."  3. Observations in 1 10/26/14 at 12:30 Fon the overbed table Resident #55 up in and the bed, remove performing hand hy the tray.  During an interview on 10/29/14 at 4:35 (DON) was asked we touching residents, passing meal trays, perform hand hygie  4. Observations on 10/28/14 at 10:09 A prepared medication knocked on Reside bathroom, touching bathroom, obtained on the overbed table performing hand hy Resident #63's lowe without performing to the bathroom, obtained the bathroom, obtained on the overbed table performing hand hy Resident #63's lowe without performing to the bathroom, obtained the performing to the pathroom, obtained the performing to the bathroom, obtained the performing to the pathroom, obtained the performing to the performin	in the staff development room AM, the Assistant Director of as asked what she expects sisting to feed a resident and er resident. The ADON stated, and I prefer them to wash their Resident #55's room on M, CNA #3 placed a meal tray e, applied gloves, assisted the bed, touching the resident ed her gloves, without giene and continued to set up in the staff development room PM, the Director of Nursing what should staff do after in between glove use, and The DON stated, "Should ne."  If the low end of the 200 hall on M, revealed Nurse #4 ns at the medication cart, nt #63's door, went to the door to room and the gloves, placed medications e, applied the gloves without rgiene, applied eye ointment to er lid, and removed her gloves, hand hygiene. Nurse #4 went of the gloves, and then went to the gloves, and then went to	F	441	The results of the audits will be reviewed by Quality Assurance Performance Improvement Committee monthly for 3 months. The Direct of Nursing is responsible for monitoring and compliance.  Date of Compliance: 11-28-14	tor	11- 28-14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRU ING			(X3) DATE SURVEY COMPLETED	
		445495	B. WING		·	10/	/30/2014	
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		490 WEST P	RESS, CITY, STATE, ZIP CODE OPLAR AVENUE ILLE, TN 38017			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	K (EAC	ROVIDER'S PLAN OF CORRECTI CH CORRECTIVE ACTION SHOUL S-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
	on 10/29/14 at 4:35 what should be don DON stated, "Should DON was asked whouching residents, administering medic "Should perform ha 5. Observations in 10/28/14 at 12:01 Padministered insulir wearing gloves. Nurknow what I did wro [while administering 6. Observations on on 10/29/14 at 9:15 preparing medication cart, pic her bare hands, and medication cup. Nurbroke a potassium gloves, and continuand administered th #51 without perform During an interview on 10/29/14 at 4:35 what should be don dropped onto the m stated, "Should disc The DON also confit touched bare hands 483.70(h)	in the staff development room PM, the DON was asked e when using gloves. The d perform hand hygiene." The last should be done after in between glove use, and cations. The DON stated, and hygiene."  Resident #83's room on M, revealed Nurse #5 to Resident #83 without rese #5 stated, "I messed up. I ang. I did not wear gloves the insulin]."  the high end of the 100 hall AM, revealed Nurse #6 was ans for Resident #51, dropped pril the Coreg onto the ked up these medications with a placed them in the rese #6 applied gloves and boill in half, removed the led to prepare medications are medications to Resident aing hand hygiene.  in the staff development room PM, the DON was asked e if pills are accidentally edication cart. The DON leard the pills and start over." immed the pills should not be	F 4					
JU-0								

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445495	B. WING		· · · · · · · · · · · · · · · · · · ·	10/	/30/2014
	ROVIDER OR SUPPLIER	COLLIERVILLE, LLC		49	REET ADDRESS, CITY, STATE, ZIP CODE 00 WEST POPLAR AVENUE OLLIERVILLE, TN 38017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	sanitary, and comforesidents, staff and This REQUIREMENT by: Based on review or and interview, it wasto ensure the environment of the environment	ovide a safe, functional, ortable environment for the public.  In is not met as evidenced of a job description, observation is determined the facility failed onment was clean, sanitary e odors on 2 of 3 (200 and ed:  The facility's housekeeper / aide umented, "The provides cleaning services promote sanitary, comfortable onment for residents, staff and the 200 hall on 10/26/14 at PM, revealed a strong e hallway.  The 300 hall as exiting the 4 at 7:05 AM, revealed a very or that permeated the hallway.  The while touring the 200 and 14 at 4:35 PM, the	F	465	I. The 200 and 300 halls were cleaned on 10 14 by the Housekeeping Supervisor.  2. An audit was conducted on 3 of 3 halls by Housekeeping Supervisor on 10-31-14 to en the environment was clean and odor free; iss were identified and addressed at that time  3. On 11-7-14, the Housekeeping Supervisor in-serviced by the Administrator in regards providing a clean, odor free environment.  On 11-10-14 the Housekeeping Staff was in serviced by housekeeping supervisor in regards to providing a clean, odor free environment.  4. Beginning on the week of 11-23-14 observational audits of the halls will be conducted by the Housekeeping Supervisor ensure the environment is clean and odor from the observational audits will be conducted times a week for 4 weeks, 1 times a week for weeks, 1 times a week for weeks, 1 times a week for the results of the audits will be reviewed by Quality Assurance Performance Improvem Committee monthly for 3 months. The Administrator is responsible for monitoring compliance.  Date of Compliance: 11-28-14	r was to	11- 28-14

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY MPLETED
		445495	B, WING			10	/30/2014
	PROVIDER OR SUPPLIER EALTH & REHAB OF (	COLLIERVILLE, LLC		49	TREET ADDRESS, CITY, STATE, ZIP CODE 90 WEST POPLAR AVENUE OLLIERVILLE, TN 38017	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	The facility must mare resident in accordar standards and pract accurately documer systematically organized information to identify resident's assessmistervices provided; to preadmission screet and progress notes.  This REQUIREMENT by:  Based on policy result interview, it was to completely and a assessments of preceded in the system of the 44 residents.  The findings included the findings inc	aintain clinical records on each noce with accepted professional tices that are complete; nted; readily accessible; and nized.  must contain sufficient ify the resident; a record of the ents; the plan of care and he results of any ming conducted by the State;  IT is not met as evidenced view, medical record review is determined the facility failed occurately document insure ulcers or pain for 2 of and 173) sampled residents included in the stage 2 review.		514	1. Resident # 128 was discharged from the facility on 6-19-14.  Resident # 173 was discharged from the facility on 11-3-14.  2. Beginning on 10-31-14 the Licensed Nurses the Treatment Nurse, Registered Nurse Supervisor, Assistant Director of Nursing, and the Staff Development Nurse conducted body audits on 99 of 99 residents; no negative issue were identified at that time.  Beginning the week of 11-3-14 the Treatmen Nurse, Registered Nurse Supervisor, Assistant Director of Nursing, and the Staff Developmen Nurse conducted an audit via observation of 6 residents identified with pressure ulcers to ensure treatments were ordered by the physic treatment orders were being administered per physicians orders, and pressure ulcer assessments were being conducted weekly; n negative issues were identified at that time.  Beginning on 11-25-14 the Assistant Directo Nursing conducted an audit of 52 of 52 resident's pain management flow records whater receiving pain medication to ensure the documentation of the resident's pain ratings, method used to relieve the pain, and the reassessment of the pain rating after the intervention was provided; issues identified vaddressed at that time.  3. The Director of Nursing in-serviced the Treatment/licensed Nurses on 10-31-14 in regards to removal of dressings and skin assessment upon admission, conducting and documenting skin assessments, documentation the correct dates on the Treatment Administration Records, and obtaining treath orders from the physician.	s,  i  is  it  int  ent 6 of  iian,  r the  o  the  were	

PRINTED: 11/17/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF AND PLAN OF C	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY MPLETED
		445495	B. WING	<u> </u>		10.	/30/2014
DOVE HEAL	SUMMARY STA	COLLIERVILLE, LLC TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREF		STREET ADDRESS, CITY, STATE, ZIP CODE 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017  PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	) BE	(X5) COMPLETION
F 514 Coa Codr [Li do bu Re and do Tr a 5/6 6/ Re do a. pr b. co c. uli d. w Re th a. b. c. d. e. f. g. Tr	certo his sacrumer to his sacrument on the following:  "5/28/14 - Resident occyx. 6/12/14 - Resident occyx.	must be preceded by full so identifying information)  ge 52  7/14 documented, "SKIN INTEGRITY BREAKS: on diagram] dry and Intact here was no skin assessment skin under the dressing of the Weekly / Monthly Body Audit out" dated May 2014 did not erns of the skin.  id not have documentation of wound assessment for 29/14 or from 6/8/14 to a staged) to his sacrum. Int #128 had a DTI to his staged) to his sacrum. Int #128 had a stage 2 pressure at #128 had a nunstageable must would be a staged and a stage an	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)  The Staff Development Coordinator and D	of BE RIATE  irrector is so on its so on its so on its so on its sed to the pain the its sed to the pain the its sed to the its sed to the its sed its sed its sed as were its sed as were its sed as were its sed as ks, its sed its	COMPLETION DATE

Facility ID: TN7941

		(X3) DATE SURVEY COMPLETED	
445495 B. WING		10/30/2014	
DOVE HEALTH & REHAR OF COLLIERVILLE 11.0	TREET ADDRESS, CITY, STATE, ZIP CODE 90 WEST POPLAR AVENUE OLLIERVILLE, TN 38017		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 514 Review of skin alert/body alert documentation revealed the following: a. 5/28/14 did not document any concerns of the skin on Resident #128's buttocks. b. 6/5/14 - Resident #128 had mild redness noted on his buttocks with a circle around the area. c. 6/11/14 - an area of concern on Resident #128's buttocks with a circle around the area. Review of Resident #128 wound care specialist evaluation forms documented the following: a. 5/29/14 - an unstageable (full thickness skin or tissue loss- depth unknown) deep tissue injury (localized area of discolored intact skin or blood filled blister) of the coccyx that resolved on 5/29/14 but had been present greater than 2 days. b. 6/12/14 - a stage 3 (full thickness skin loss subcutaneous fat may be visible) pressure wound of the sacrum with recommendations for wound care. c. 6/19/14 - an unstageable wound of the sacrum with recommendations for wound care. The facility was unable to provide documentation of any braden scale assessments completed.  Review of the May 2014 Medication Administration Record (MAR)documented the wound treatment to cleanse sacral wound with wound cleanser, pat dry and apply hydrocolloid every 3 days was documented as being done on 5/8/14 through 5/11/14. Resident #128 was not admitted until 5/27/14.  Review of the MAR dated 5/2014 (the DON stated this was actually a MAR for 6/2014, and was an inaccurate date) documented, "cleanse searcal wound cleanser, nat dry	Beginning the week of 11-23-14, the License Nurses, Treatment Nurses, and/ or the Regist Nurse Supervisors, will conduct weekly skin assessments on the residents. The assessment will be reconciled against the resident census the Assistant Director of Nursing and/or Registered Nurse Supervisor weekly.  Beginning the week of 11-23-14, the Certific Nursing Assistants will conduct body audits the residents three times weekly. The assessments will be reconciled against the resident census by the Assistant Director of Nursing, Treatment Nurse, and/or Registered Nurse Supervisor 3 times weekly.  Beginning the week of 11-23-14 3 residents management flow records will be audited by Registered Nurse Supervisor, Assistant Dire of Nursing, and/or Staff Development Coordinator to ensure documentation reflect resident's pain ratings, the method used to relieve the pain, and the reassessment of the rating after the intervention is provided. The audits will be conducted 3 times a week for weeks, 1 times a week for 4 weeks, monthly 1 month, then quarterly thereafter.  The results of the audits will be reviewed by Quality Assurance Performance Improveme Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and compliance.  Date of Compliance: 11-28-14	ts s by  d on  f  pain the ctor s the pain f  for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1				E SURVEY IPLETED
		445495	B. WING			10/	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC	<u>'</u>	49	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST POPLAR AVENUE OLLIERVILLE, TN 38017	<u> </u>	- VO/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	apply hydrocolloid of order" There were for 5/27/14, 5/28/14 Review of a wound documented on 6/8 Resident #128 had ulcer of the sacrum Review of a Patient documented the folia. Week 1 dated 5/2 c PU [pressure ulb. Week 2 dated 6/5 skin concerns. c. Week 3 dated 6/5 cleanse sacral oper dry, & [and] apply hy Review of Resident the following: a. 5/27/14 - "Probledue to paraplegia pressure reducing sib. 6/12/14 - " press Approaches week	p [every] 3 days until further a no treatments on the MAR for 5/29/14.  healing progress report 1/14, 6/12/14 and 6/19/14 that an unstageable pressure at High Risk (PAR) notes lowing: 28/14 - "Resident admitted	F	514	DEFICIENCY)		
	on 10/28/14 at 4:25 stated, "I don't stage wound is when a re measure it. Then ca and she tells me whassessments." Trea wound care doctor measurements and	in the staff development room PM, Treatment Nurse #1 e. The only time I measure the sident comes in and I all [named wound care doctor] nat to put down for atment Nurse #1 stated, "The and the doctor does the I will write down the doctors's then place them in the			·		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445495	B. WING		i	10/30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		STREET ADDRESS, CITY, STATE 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017		
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F 514	computer for the facare doctor keeps to writes, the only infocassessments is the doctor once it is donot need the information copy. The certified nurses do skin assenurses also use the completes the formation nurse, and after 3 materials pressure ulce "He had a DTI when the treatment Nurse # 128 pressure ulce "He had a DTI when the treatment Nurse # 1 stated, "Nourse #1 stated, "Nourse demonstrates a trisk, dis RD [Registered Die like a mattress. This have a written protoprocess." The Nurse do the nurses know policy. The Nurse Control of the Nurse Control o	ge 55 cility's documents. The wound he documentation that she rmation the facility has for dictation from the wound care cumented. The facility does ration and we do not keep a nursing assistants (CNAs) and essments with the baths. The skin audit sheet, the nurse, and gives to the treatment nonths, they are discarded." I was asked about Resident Treatment Nurse #1 stated, he came in [5/27/14]." I was asked if the nurses and documentation. Treatment to ma'am. I don't see any."  In the staff development room PM, the Nurse Consultant icy for skin assessments and urse Consultant stated, "If a high risk they go through PAR plinary team. We discuss cuss patient's needs with the tician] and if needs equipment is is all we've got. We don't cool. I can tell you our e Consultant was asked how what to do if there is no consultant stated, "We have a in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM, the Nurse Consultant decided in the staff development room PM and the staff development room PM and the staff development room PM and the staff developmen	[   F {	514		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		445495	B. WING		10	/30/2014	
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017			
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F 514	at the skin." There skin assessment producted.  During an interview on 10/29/14 at 10:3 was asked where the unstageable DTI of dictated form. The remember looking to the wound care do receives her inform building and the fact wound care doctor or they see someth them what to put do it." The wound care documented a stage did she remember adocumented a stage did she remember adoctor stated, "Calle [Named Treatment wound looked, rountreatment nurse can the phone and that During an interview on 10/30/14 at 12:3 (DON) was asked in Daily / Weekly / Moreport was consider assessment. The Discontinuation of the phone asked what the skin asked what	was no documentation of a rovided when the resident was in the staff development room 5 AM, the wound care doctor he information for the the coccyx came from on the wound care doctor stated, "I for it and it not being there." In the action from if she is not in the ation from if she is not in the stated, "If they are suspicious ing they will call me and I tell own. I will go back and look at a doctor was asked about 6/12/14 where she had e 3 pressure wound, and what about this. The wound care ed me on the weekend, it was Nurse #2], told me how the hids would be later. The in not stage, it is described on	F 5				
	should assess the v "Yes, should be doo looks like." The DO	wound nurse comes in she wound." The DON stated, curnented what the wound N was asked about the inds. The DON stated. "The		-			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445495	B. WING			10/	30/2014
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		49	TREET ADDRESS, CITY, STATE, ZIP CODE 90 WEST POPLAR AVENUE OLLIERVILLE, TN 38017	100	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	staff could not learn. The information [na would put in did not [named wound care stages never match.]  2. Review of the fa policy documented, to screen residents indicated for cause what relieves the pareceive treatment for then monitored for e0- [to] 10 (0 = [mean should be utilized for Medical record revied documented an addiagnoses of Congel Hypertension, Hype of the Lower Left Left Review of the cogni 10/16/14 document were consistent and make himself under memory problems, impairment.  Review of the admit 10/16/14 document in the past 5 days were stages.	e did have was difficult, the it or had difficulty learning it. med Treatment Nurse #2] match the information that doctor] had on her notes, the ed.  cility's pain management "It is the policy of this facility for pain and further assess if and severity of pain as well as ain. All residents should or pain relief as warranted and effectiveness A pain scale of its no pain, 10 = worst pain) or the adult resident"	F	514			
	Review of Resident flow sheet part of th Sheet (MAR), for O						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445495	B. WING_		10/30/2014	
	PROVIDER OR SUPPLIER	COLLIERVILLE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 490 WEST POPLAR AVENUE COLLIERVILLE, TN 38017		
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F 514	reassessment of the intervention was properties. Review of a physic documented the respective medication, Lortab hydrocodone and 3 by mouth every 6 head for pain control. The dated 10/23/14 incolumntary and interview 10/27/14 at 8:40 All Lortab 10/325 relies. During an interview on 10/29/14 at 10:1 (DON) was asked, documenting the acoff a resident's pain indicated the resides should be recorded.	ieve the pain, or the pain rating after the ovided.  ian's order dated 10/16/14 sident was to be given the pain 10/325 mg (10 mg of 25 mg of acetaminophen) one ours as the resident needed e wound specialist's order reased the frequency of the ours as needed due to	F 51	4		
	flow sheet.			RECEIVED DEC 0 1 2014		